

Today's Date: _____ Due Date: _____ ASU ID Number _____

The Disability Resource Center (DRC) provides on-campus transportation to students, staff and faculty with limited mobility due to a medical condition(s). Any participant with an ambulatory disability is required to have this form completed by their attending medical provider. Please return completed form by fax or email to DRC@asu.edu upon receipt of this verification. Services will be suspended if the form is not complete and/or not returned by the deadline indicated above.

I _____ give permission for my medical provider to release relevant medical information to Disability Access and Resource Transportation (DART) located at Arizona State University, DRC for the purpose of making the appropriate accommodations. You can reach me at _____ if you have any questions.

Patient Signature: _____ Date: _____

TO BE COMPLETED BY MEDICAL PROVIDER

Your Patient has requested transportation services on the basis of a medical condition that significantly impacts his/her ability to walk. It is necessary to complete the following information in order that we may provide the accommodation. Information provided will remain confidential and will not be shared with anyone. Please take into account the environmental conditions that may also impact the patient's condition. ie: intense summer heat, etc.

- A. Describe injury/illness: _____
- B. Patient is limited to walking _____ feet.
- C. Patient's maximum walking distance is _____ feet.
- D. Patient is expected to begin walking on own in _____ week(s). (weight bearing, rehabilitation, etc.)
- E. Patient is expected to fully recover in _____ weeks(s).

MEDICAL PROVIDER INFORMATION

Medical Provider's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

COMMENTS: _____ Office Phone: _____ Fax: _____

Medical Provider Signature: _____ Date: _____

DISABILITY RESOURCE CENTER

FAX: (480) 965-0441

(480) 965-1234

DRC@asu.edu

<https://eoss.asu.edu/drc>

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