

HONOLULU COMMUNITY COLLEGE

Student ACCESS

PHYSICIAN'S VERIFICATION FORM – ELEVATOR

Confidential

Rec'd ___/___/___ Comp Req Rep
Thru: Fall Spring Sum ___/200___

Please print clearly. Incomplete forms will not be processed.

Return to Student ACCESS Office, 874 Dillingham Blvd. (7-319), Hon., HI 96817 or FAX 808-844-2391.

Banner I.D. # or Birthdate

Last Name

First Name

M.I.

Mailing Address

City

HI

Zip Code

Phone (please circle: home/work/cell)

Email address

@

Students: Submit to Student ACCESS this completed form or provide a photocopy of your State of Hawai'i Disability Parking Placard I.D. card to request floor-to-floor elevator access to get to your classes. All students requesting this accommodation should inform Student ACCESS of their abilities to get to and from class when this floor-to-floor elevator is out-of-service or in the event of an emergency. For questions, please call 844-2392 (voice/text).

Physicians: Please complete all sections below with your signature and official stamp. Thank you!

► ELEVATOR REQUEST:

My patient's condition is _____.

Please mark reason and elaborate:

- Inability to walk up and/or down the stairs.
- Other reason: _____.

Accommodation should be for: ___ week's ___ this semester only ___ this academic year.

❖ If the floor-to-floor elevator becomes inoperable up to 3 days (short term), my patient:

- Can walk up or down a half flight of stairs to get to/from class.
- Cannot walk up or down a half flight of stairs to get to/from class.
 - Relocate class ___ Yes or ___ No
 - Impact if unable to relocate class: _____

❖ If the floor-to-floor elevator becomes inoperable for more than 3 days (long term), my patient:

- Can walk up or down a half flight of stairs to get to/from class.
- Cannot walk up or down a half flight of stairs to get to/from class.
 - Relocate class ___ Yes or ___ No
 - Impact if unable to relocate class: _____

❖ In an emergency, in order to exit the building, my patient:

- Can walk down the stairs & does not require help.
- Can walk down the stairs but requires help.
- Cannot walk down the stairs and would need evacuation assistance.

EXAMINING PHYSICIAN TO SIGN

As M.D., I attest the above to be true.

X _____
Physician's Signature

Date

Phone #

Official Stamp

Printed Name

Address