OAA·EOP
University of Pennsylvania
Access • Diversity • Inclusion

**Please return completed materials to:**
**Office of Affirmative Action and Equal Opportunity Programs**
**3451 Walnut Street**
**Franklin Building, Suite #421**
**Philadelphia, PA 19104-6205**

# PENN ACCESS TRANSIT MEDICAL AUTHORIZATION FORM

**215-898-6993 (voice)** **215-746-7088 (fax)**

## SECTION I: TO BE COMPLETED BY EMPLOYEE:

Employee Name:_____ Job Title:_____

Department:_____ Supervisor:_____

Contact Number:_____

### RELEASE OF INFORMATION

I hereby authorize the release of the following information to the University of Pennsylvania for the purpose of authorizing use of Penn Access Transit. I understand that all medical documentation will be kept confidential.

Employee Signature:_____ Date:_____

## SECTION II: TO BE COMPLETED BY PHYSICIAN OR CARE PROVIDER:

1. Please indicate the reason the employee needs to use Penn Access Transit:

_____

_____

_____

_____

_____

2. Please indicate the dates the employee will need to use the service:

**TEMPORARY** **From:**_____ **To:** _____

**PERMANENT**

### PLEASE SIGN BELOW:

_____ _____

**Signature of physician or care provider** **Date**

**Provider Name:** _____

**Provider Address:** _____

_____

**Provider Telephone:** _____ **Provider Fax:**_____