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:**_____