One Boston Place

Registration Form for Employees with Disabilities

Date: ______________________________

Employee Name: ______________________________

Employer: ______________________________

Floor: ______________________________

Nearest Stairwell: NORTH or SOUTH
(circle one)

Duration of Disability: **Permanent** __________ **Temporary** ____________
(End Date)

Nature of Disability:

(circle one)

Restricted Mobility (wheelchairs, walkers, canes, crutches)

Sight Impairment

Hearing Impairment

Cognitive Impairment

Emotional Impairment

Person of Size

Phobia (Heights, Elevators, etc.)

Physical Impairment

Elderly

Pregnancy (Month/Year Due ___________)

Other ____