

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: _____