

MCG PARKING OFFICE - APPLICATION FOR DISABLED PARKING

Instructions: Please fill out this form in legible print or type. Your supervisor and your treating physician must indicate specifically what reasonable accommodations are needed for you. Please make sure that all information is complete or your application may not be processed. MCG Policy allows that reasonable accommodations include (but are not limited to) spaces close to buildings or spaces close to shuttle stops. Physician must be licensed to practice medicine, podiatric medicine or chiropractic.

1.) Requesters Name (print or type) _____ Date _____

2.) MCG Work site (Bldg/Rm#) _____ Working Hours: _____ Work Phone: _____

3.) Vehicle State/Tag Number (Ex. Ga/123MPR) _____ State Permit Number _____

Year _____ Make _____ Model _____ Color _____

4.) Briefly describe the walking disability and how it affects your mobility.

5.) Describe the assistance that you require to assist your mobility (such as walking aids, wheelchair, scooter, handrails, ramps, etc.).

Statement of Compliance with State Law:

I understand that by signing this form I am certifying that I meet the criteria for disabled parking requirements contained in this policy, and I understand that any false representations in this application are grounds for disciplinary action and/or criminal prosecution.

Signature of requestor: _____

Signature of Notary (required) _____

TO BE COMPLETED AND SIGNED BY DIRECT SUPERVISOR & DEPARTMENT HEAD

Supervisor: Does this employee's job require walking distances of 200 feet or more? Yes or No. (Circle one)
 Does this employee's job require walking up stairs of two or more? Yes or No. (Circle one)

6.) Please describe any reasonable accommodations that you are aware are needed for this employee and any provided by your department.

*Name of Supervisor (Print) _____ Signature of Supervisor _____

*Name Department Head (Print) _____ Signature of Dept Head _____

Physician's Affidavit

1.) Requester's Name (print or type) _____ Date _____

Requester's Home Address _____

(City) (State) (Zip Code)

TO BE COMPLETED AND SIGNED BY PHYSICIAN TREATING FOR CONDITION AFFECTING MOBILITY

***Attending Physician:** Please answer the following questions and check any conditions that apply:

I hereby swear and affirm that the above named individual is disabled as indicated.

Is the patient disabled such that the patient cannot walk a distance of 200 feet without stopping to rest? Yes or No

Is the patient unable to walk without the use of assistance from a brace, cane, crutch, another person or a prosthetic device, a wheelchair, or other assistive device? Yes or No

Is the patient unable to climb two stairs without assistance of any of the above named devices? Yes or No

Is the patient's disability permanent? Yes or No

Conditions (check any that apply to this patient):

Patient uses portable oxygen.

Patient has a cardiac condition to the extent that his or her functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.

Patient is restricted by lung disease to such an extent that his or her forced respiratory volume for one second, when measured by spirometry, is less than one liter, or when at rest, his or her arterial oxygen tension is less than 60 milliliters of mercury on room air.

Patient is severely limited in his or her ability to walk due to an arthritic, neurological, or orthopedic condition or complications due to pregnancy.

If not permanent, please give a date that the disability is expected to end _____

7.) Please briefly describe medical condition & any reasonable accommodations needed for this employee's mobility.

*Name of Physician (Print) _____ Georgia or South Carolina Practitioner Number _____

Signature of Physician _____ Notary Signature (Required) _____

Physician's Address _____

(City) (State) (Zip Code)