Southeast community college

Return completed form to:
SCC Physical Plant

Beatrice Campus
4771 West Scott Road
Beatrice, NE 68310-7042

Lincoln Campus
8800 O Street
Lincoln, NE 68520-1299

Milford Campus
600 State Street
Milford, NE 68405-8498

MEDICAL STATEMENT – VERIFICATION OF A DISABILITY OR TEMPORARY DISABILITY

The applicant named on the reverse side of this form is requesting a temporary permit to use restricted parking at a Southeast Community College location.

To obtain a temporary permit to use restricted parking on campus, **the applicant (permit holder) must have a verifiable disability or temporary disabling condition that limits their mobility and access to SCC facilities.**

The applicant qualifies as a person with a disability or temporary disability because:

REQUIRED INFORMATION FROM PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER
Please indicate qualifying disability/condition, temporary status, and estimated time of recovery -

- ______ The applicant is an individual with a severe visual or physical impairment which limits personal mobility and results in an inability to travel unassisted more than two hundred feet without the use of a wheelchair, crutch, walker, or prosthetic, orthotic, or other assistive device; **OR**
- _____ The applicant is an individual whose personal mobility is limited as a result of respiratory problems; **OR**
- _____ The applicant is an individual who has a cardiac condition to the extent that his or her functional limitations are classified in severity as being Class III or Class IV, according to standards set by the American Heart Association; **OR**
- _____ The applicant is an individual who has permanently lost all or substantially all the use of one or more limbs, **AND**
- _____ **The applicant is a temporarily disabled person whose personal mobility is expected to be limited in the manner listed above for no longer than six months.**

Estimated time of recovery (# OF WEEKS):
____

MEDICAL CERTIFICATION/VERIFICATION

I hereby certify that I am a physician, or a physician assistant, or nurse practitioner currently authorized to practice in the State of Nebraska, and that the individual making this application has a verifiable disability or temporary disability as defined in the Nebraska Revised Statutes and indicated above.

____ ________________________
Signature of physician, physician assistant, or nurse practitioner **Date**

Printed Name____

Address____

____

Telephone____

Information provided courtesy of: Southeast Community College Access/Equity/Diversity Office