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