

LEBANON VALLEY COLLEGE  
Application for Disability Parking Permit

**SECTION I – Applicant**

Name \_\_\_\_\_ Campus Phone \_\_\_\_\_

Campus Address \_\_\_\_\_

I am requesting a disability parking permit due to the following mobility problems and/or medical conditions:

\_\_\_\_\_

By signing below, applicant authorizes physician to complete Section II below, and to release information regarding medical condition.

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

**SECTION II – Physician**

For the purposes of this section, persons with disabilities which limit or impair the ability to walk means persons who: **Cannot walk 200 feet without stopping to rest; Cannot walk without the use of, or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assisting device; Are restricted by lung disease; Use portable oxygen; Have a cardiac condition; Are SEVERELY limited in their ability to walk due to an arthritic, neurological, or orthopedic condition.**

1. Specific diagnosis of medical condition: \_\_\_\_\_

\_\_\_\_\_

2. Date of injury or onset of illness or medical condition: \_\_\_\_\_

3. Is condition permanent? \_\_\_\_ Yes \_\_\_\_ No; If no, how long will applicant be disabled? \_\_\_\_\_

4. How does the disability or medical condition conform to the above criteria (**be specific**) \_\_\_\_\_

\_\_\_\_\_

5. Include or attach information on test results, surgeries, medication, or other information that supports this request (e.g. pulmonary function studies for asthma). Impairments are considered medically determinable if they manifest themselves as signs in laboratory findings, apart from symptoms. **Abnormalities, which manifest themselves only as symptoms, are not considered medically determinable.**

6. Does the applicant require aids for walking, e.g. cane, walker, wheelchair, or other assisting device? \_\_\_\_ Yes \_\_\_\_ No; If yes, please specify \_\_\_\_\_

7. Other information or comments in support of this application for disabled (special parking) attach additional sheets if necessary \_\_\_\_\_

\_\_\_\_\_

Physician Name (please print) \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_

Return form to:

Office of Disability Services  
Lebanon Valley College  
101 North College Avenue  
Annville, PA 17603  
Phone: (717) 867-6071  
Fax: (717) 867-6091