CERTIFICATION OF HANDICAP FOR RESERVED PARKING

EMPLOYEE INFORMATION

NAME *(Last, First, Middle Initial)*	OFFICE
ADDRESS *(Street, City, State, Zip Code)*	ROOM NUMBER
	OFFICE PHONE NUMBER

TO BE COMPLETED BY ONE OF THE FOLLOWING *(Check Appropriate Box)*

☐ DoD MEDICAL UNIT ☐ VETERAN'S ADMINISTRATION ☐ PUBLIC HEALTH

PHYSICIAN'S STATEMENT

NATURE OF HANDICAP *(in Layman's Terms)*

☐ **I have examined the individual named above, and certify that he/she has a severe permanent physical or mental impairment, which precludes the use of public transportation.**

☐ **The individual above is capable of using public transportation.**

SIGNATURE OF PHYSICIAN	DATE SIGNED

PARKING ASSIGNMENT

LOT _____ SPACE _____

REMARKS/COMMENTS