Form Fillable Version

U. S. Department of the Interior (DOI) - Physician's Certification Application for Disabled Parking

Mandatory for issuance of a disabled permit for parking. (Please type or print)

Medical documentation to support the application of a disabled employee for a special parking permit is required, and reviewed in accordance with this standard. Employee must complete section 1 and have your physician complete section 2 & 3 and sign this report.

EMPLOYEE

1) I _____ [ ] **Agree** [ ] **Disagree** to authorize the U.S. Public Health Service (PHS) designated physician to receive medical records and /or discuss my medical condition with the following care provider(s):

a. Bureau/Office_____ b. Work Telephone:_____

I understand that the information collected and discussed is to be treated confidentially. However, directly relevant information may be shared with the DOI Parking Office.

Signature:_____ Date:_____
(Employee)

PHYSICIAN

2) Explain the medical basis for any conclusion that the individual is precluded/restricted from using public transportation or participating in ridesharing - include diagnosis and how it limits employee's mobility:

a. Will there be an expected change in the individual's condition over the next year (e.g., surgery planned or foreseen)? Yes [ ] No [ ]

b. How far can the individual walk from his/her car to the office without symptoms or causing danger to themselves?
10-80 yards, no stairs [ ] 150 yards, less than 10 stairs [ ] 300+ yards, less than 10 stairs and travel escalators [ ]

c. Does the individual use any aids for mobility impairment (e.g., cane, electric cart, wheelchair, cast, crutches)? Yes [ ] No [ ]

Specify:_____

d. Is this a temporary request for parking? Yes [ ] No [ ]

If yes, what is the expected duration? _____Week(s) _____Month(s) If more than two months please explain:

PHYSICIAN

3) Based on the above, I certify that this individual's disability is so severe that it precludes the use of public transportation or participating in ridesharing.

Name of Physician:_____ Signature:_____
(Print)

Date:_____ Telephone:_____

PHS MEDICAL REVIEW

Disabled Parking Assignment Approved: Yes [ ] No [ ] Date of PHS Determination:_____

[ ] Temporary (Duration):_____ [ ] Permanent

Parking Location: Main Interior Building [ ] South Interior Building [ ] Federal Reserve Building [ ]

Signature:_____ Title:_____

Comments:_____

Privacy Act Statement: Federal Property Management Regulations, Section 101-20.104, Parking Facilities, authorizes the collection of all information which will be used by the DOI, Parking Office and the U.S. Public Health Service, to determine your eligibility for a parking space. Failure to provide the information requested on the form may result in denial of a parking permit.

(October 2003)

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