

FORM 2
Persons with Disabilities Handicap Parking Form

Directions: Section A of this document must be filled out completely and signed by a physician. Section B (next page) must be completed by the applicant.

Section A:

Definition: PERSONS WITH DISABILITIES

"A natural person who, as determined by a licensed physician (1) cannot walk without the use of, or assistance from a brace, cane, clutch, another person, with prosthetic device, wheelchair, or other assistive device; (2) is restricted by lung disease to such an extent that his or her forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 mm/hg on room air rest; (3) use portable oxygen; (4) has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV, according to standards set by the American Heart Association; (5) is severely limited in the person's ability to walk due to an arthritic, neurological or orthopedic condition; (6) cannot walk 200 feet without stopping to rest because of one of the above 5 conditions."

(Please fill in the name of the person with the disability, state the diagnosis and indicate the impairments below.)

Name of Person with Disabilities _____

Diagnosis: _____

- _____ Is restricted by lung disease to such a degree that the person's forced (respiratory) expiratory volume (FEV) in one second when measured by spirometry, is less than one liter.
- _____ Uses portable oxygen.
- _____ Has a Class III or Class IV cardiac condition according to the standards set by the American Heart Association.
- _____ Cannot walk without the assistance of another person, prosthetic device, wheelchair, or other assistive device.
- _____ Is severely limited in the person's ability to walk due to an arthritic, neurological or orthopedic condition.

LENGTH OF DISABILITY: Check one

_____ Disability is permanent _____ Disability is temporary – must state duration (maximum 6 months)

I hereby certify that the physical condition of the person with disabilities listed herewith constitutes him/her as a person with disabilities.

Physician's Signature

Physician's License Number

Supervising Physician's Name

License Number

PLEASE PRINT OR TYPE BELOW:

Physician's Name _____

Address _____

City _____

Telephone (_____) _____

Please Mail all required documentation to: ADA Coordinator, 4245 Highway 162, Granite City, IL 62040

Section B: PERSON WITH DISABILITIES

I hereby apply for:

_____ Person with Disabilities Handicap Parking

Certify that my physical condition entitles me to the issuance thereof. I am also aware that the person with disabilities parking must be used by handicap parking person only.

_____ Date _____ Applicant Signature

PLEASE PRINT OR TYPE BELOW

Name of Individual with Disability	Gender		Date of Birth (Month/Day/Year)
	Male	Female	
Address	City		Zip
			Driver's License # OR State ID Card Number of Individual with Disability
Telephone		()	

HANDICAP PARKING FOR PARENT, IMMEDIATE FAMILY MEMBER OR LEGAL GUARDIAN ONLY:

I hereby apply for handicap parking as the parent or legal guardian of the individual with a disability. The above named person with disabilities, owns no vehicles and relies frequently on me for his/her mode of transportation.

Parent's Name, Legal Guardian's Name or Family Member's Name		Date
Address	City	Zip
	Telephone Number	
Relationship to Disabled Person		