LEHIGH UNIVERSITY PARKING SERVICES
MEDICAL REQUEST FOR SPECIAL TRANSPORTATION/PARKING

STUDENTS: Please read this form and print or type all requested information. The information on this form will be used by University departments and shall be considered confidential by the University. A copy of your class schedule must accompany this form.

____

Name Lehigh ID Number Class

____

Local Address Local Telephone

Do you have a handicapped placard or license plate for your vehicle?

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____

I authorize the physician named below to release information about my medical condition. In addition to having my physician complete this form, I understand that it may be necessary for the staff of Lehigh University Parking Services and a consulting physician to review actual medical records that relate to my condition. I authorize the physician below to complete this form and to release additional relevant medical records if requested by Lehigh University.

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Date Applicants Signature

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PHYSICIANS STATEMENT: Your patient has requested special parking or transportation on the Lehigh campus. The University has limited parking on the Asa Packer Campus, but tries to accommodate special needs when an individual has a medical condition, which warrants such privileges. Please assist us in determining the best possible transportation alternative for your patient by providing us with the following information. Use reverse, if necessary.

1. What is the nature of the patient's disability? Please detail and add any comments which will give us a better understanding of your patient's disability.____

   ____

2. What is the expected duration of the condition? ______#Weeks ________#Months _______Permanent _______Other

3. What distance can the patient reasonably be expected to walk? None_____ One block_____ 2 to 5 blocks_____ More_____

4. Can patient wait for a bus? _____ Can patient climb steps? _____ Can patient ride a bus? _____

5. Is the patient receiving physical therapy? _____ If yes, describe? ____

   ____

6. Can the patient participate in any athletic programs? _______

7. Is there any other relevant medical information of which we should be aware? (Attach additional sheet, if needed.)____

____

Physicians Name & Specialty Signature (must be signed by Physician) Date

Address____ Phone____________________________

Please return this completed form to the Office of Disability Services
31 Williams Hall
Bethlehem, PA 18015