

***Initial Application Procedure for a Handicapped Parking Permit***

- Complete a *Petition for Accommodations*.
- Complete the *Handicapped Parking Permit Application*.
- Have your doctor complete and sign the *Medical Verification Form*.
- Return the completed *Parking Permit Application* to the Office of Disability Support Services.
- Provide License Plate Number: \_\_\_\_\_
- Provide Adelphi University Parking Decal Number: \_\_\_\_\_
  
- **The Parking Permit must be displayed in the dash of your vehicle any time that you are using handicapped parking on campus.**
- **The Parking Permit must be renewed annually.**
- **The Parking Permits are issued only to students who are currently enrolled in the University.**



OFFICE OF DISABILITY SUPPORT SERVICES  
UNIVERSITY CENTER - ROOM 310  
tel. (516) 877-3145  
fax (516) 877-3139  
tty (516) 877-3138

*Handicapped Parking Permit Application*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Home Address:

Telephone Number:

Please Describe Handicapped Condition:

Name of Physician:  
Address of Physician:  
Telephone Number of Physician:

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I hereby certify that the above statements are true and authorize the physician named above to furnish any information requested by the Coordinator of the Office of Disability Support Services concerning the diagnosis, prognosis and treatment of my described condition.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_



*Medical Verification Form*

In accordance with the New York State definition of “Severely Disabled Person”, Adelphi University requires the following information:

Patient Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Please check applicable condition(s):**

“Severely Disabled Person” shall mean any person who has any one or more of the following impairments, disabilities or conditions, which are permanent in nature.

- Has limited or no use of one or both lower limbs.
- Has a neuro-muscular dysfunction, which severely limits mobility.
- Has a physical or mental impairment or condition which is other than those specified, but is of such nature as to impose unusual hardship in utilization of public transportation facilities and such condition is certified by a physician duly licensed to practice medicine in this state as constituting an equal degree of disability (specifying the particular condition) so as to prevent such person from getting around without great difficulty in accordance with subdivision two of this section.

**Please describe Handicapped Condition:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe Limitations in Ambulating (include use of aids to walking such as cane, crutches, walker, braces wheelchair, prosthesis, other):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this condition permanent? \_\_\_\_\_

**I AM A MEDICAL DOCTOR LICENSED TO PRACTICE IN NEW YORK STATE, AND IN MY PROFESSIONAL OPINION, I BELIEVE THAT APPLICANT’S MOBILITY-IMPAIRING CONDITION DOES WARRANT A HANDICAPPED PARKING PERMIT, ACCORDING TO THE ABOVE DEFINITION OF “SEVERELY DISABLED”.**

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

N.Y.S. Practicing License Number: \_\_\_\_\_