

IMPORTANT

DISABLED PERSONS PARKING PERMIT INFORMATION

TO OBTAIN A PARKING PERMIT:

1. Complete the applicable sections on the reverse side of this form.
2. Obtain your doctor's certification on the form.
3. Bring the form to WSU Vancouver Parking Services (in the Physical Plant building) at 14204 NE Salmon Creek Ave., Vancouver, WA, 98686 or fax to (360) 546-9061.
4. For questions, email parkingservices@vancouver.wsu.edu or call (360) 546-9009.

IT IS ILLEGAL TO:

- Lend your disability parking permit to another person.
- Forge a doctor's signature.
- Use another person's disability parking permit.
- Provide false information to obtain a disability parking permit.
- Alter a disability parking permit.
- Possess or display a counterfeit disability parking permit.

REMEMBER:

- The only legal use of a permit is its display by the person to whom it was issued. The disabled person does not have to own or drive the vehicle to use the permit. However, the disabled person must be in the vehicle when parking in a disability space. Dropping the disabled person off and then parking in a disability space will NOT be allowed.
- Illegal use of a disability permit can result in cancellation and revocation of the permit and loss of the privileges it provides. A fine will also be assigned.

TEMPORARY DISABILITY PERMITS:

- Specific dates must be provided by the medical professional. ("Specific dates" should read similar to the following: "From 05-15-05 to 07-15-05" - **Note: A form that simply states "2 months" will NOT be accepted**).

WSU Vancouver Parking Services
DISABILITY PERMIT APPLICATION

APPLICANT'S NAME: (LAST) _____ (FIRST) _____ (M.I.) ____
APPLICANT'S ADDRESS: (STREET) _____
(CITY) _____ (STATE) _____ (ZIP CODE) _____

APPLICANT'S SIGNATURE: _____ (DATE) _____

DOCTOR'S CERTIFICATION OF DISABILITY

(MUST BE COMPLETED BY A PHYSICIAN OR AUTHORIZED MEDICAL PROFESSIONAL BEFORE WE
CAN PROCESS YOUR APPLICATION.)

DURATION OF DISABILITY: (CHECK ONE)

PERMANENT

TEMPORARY; (Length of temp. disability): (From: _____ to: _____)

TYPE OF DISABILITY: (Please check the appropriate condition(s) that apply to your patient.)

Any licensed physician may certify to items 1-8. A licensed chiropractor may certify to items 2 and 7. A licensed ophthalmologist or optometrist may certify to item 8 only.

1. A diagnosed disease or disorder which substantially impairs or interferes with mobility or requires the aid of an assistant device for mobility (e.g. cane, walker, crutches, etc.) due to:

2. A significant limitation in the use of the lower extremities which substantially impairs or interferes with mobility or requires the aid of an assistant device for mobility (e.g. cane, walker, crutches, etc.) due to: _____

3. Uses portable oxygen.

4. Lung disease to such an extent that forced (respiratory) expiratory volume for one second when measured by spirometry is less than one liter or arterial oxygen tension (PO₂) is less than 60 mm/HG on room air at rest.

5. Impairment by cardiovascular disease. (*The American Heart Association Standard*)
(Please check one) Class III Class IV

6. Loss of, or loss of the use of, one or both hands. Loss of use due to: _____

7. Loss of, or the loss of the use of, one or both lower extremities. Loss of use due to: _____

8. Central visual acuity not exceeding 20/200 in the better eye, with corrective lenses, as measured by the Snellen test or visual acuity greater than 20/200 with a limitation in the field of vision such that the widest diameter of the visual fields subtends an angle not greater than 20 degrees.

I CERTIFY I AM A Physician Chiropractor Ophthalmologist Optometrist and that the applicant has the disability indicated above. I certify under penalty of perjury under the laws of the State of Washington that the information I have provided is true and correct. I understand that Washington Law allows issuance of special parking privileges only to persons with severe mobility disabilities that limit their ability to walk.

MEDICAL PROFESSIONAL'S SIGNATURE: _____

FULL NAME: (LAST) _____ (FIRST) _____ (M.I.) _____

PROFESSIONAL LICENSE NUMBER: _____

MEDICAL PROFESSIONAL'S ADDRESS: (STREET) _____

(CITY) _____ (STATE) _____ (ZIP CODE) _____