Record #:_____

Temporary Accessible Parking Application

Persons with temporary disabilities who need accessible parking accommodations can apply for a Temporary Accessible Parking Permit. The applicant must be a student, staff, or faculty of the university and have registered their vehicle with the Department of Campus Safety. A licensed physician will need to provide justification for accessible parking privileges and sign the *Temporary Accessible Parking Application*. The clinician submitting the documentation must not be a family member or relative of the applicant. The *Temporary Accessible Parking Application* is to be turned in to the receptionist in Administration Building Suite 120.

The application will be reviewed by the Director of Campus Safety, Director of Disability and Learning Services, and the Director of Health Services. Upon receipt of the application, **the applicant may be issued a temporary parking permit valid for 21 days to obtain a Disabled Person Parking Placard from the Department of Motor Vehicles**. After 21 days, the applicant must present a Disabled Persons Parking Placard to continue to use accessible parking privileges.

Persons who have been approved for accessible parking must understand that the Temporary Accessible Parking Permit does not allow parking in the following areas:

- Disabled Person Parking stalls designated in blue stall markings (CVC 22507.8)
- Fire Lanes and Red Zones (CVC 22500.1)
- Sidewalks, roadways, or other pathways
- Neighboring residential communities
- Lawns or other landscaped areas

A Temporary Accessible Parking Permit does not guarantee that accessible parking will be available at the time of need. Safety Escorts are also available for those with temporary disabilities. Campus Safety Dispatch can be reached at all times by phone at (949) 214-3000.

To be completed by the APPLICANT:

Name: _____ Phone: _____ Date of Birth: _____

Home Address: _____

City:_____ State: _____ Zip Code: _____

Residence Hall Address:_____ Room Ext.: _____

Please check status: [ ] Student [ ] Faculty/Staff E#_____ Driv. Lic.:_____

Do you currently have a CUI parking permit? Yes No Parking Decal #:_____

Please list vehicles you have registered with Concordia University's Department of Campus Safety:

License Plate #	State	Vehicle Make	Model	Color

Are you requesting temporary or permanent disability parking? [ ] Temporary [ ] Permanent

Are you registered with the Disability and Learning Resource Center? _____

Please describe why you are requesting accessible parking privileges: _____

_____

_____

By my signature, I voluntarily authorize my physician to release the information requested to Concordia University, Irvine. Additionally, I certify that I have read the Temporary Accessible Parking Policy and will not provide false information, will not falsify a doctor's signature, possess or display a counterfeit or altered placard, or allow someone to use my placard if I am not in the vehicle.

_____ _____

Signature Date

Doctor's Certification of Disability

A full legible description of the illness or disability must be provided for numbers 3, 4, 5, 6, and 7 below. A licensed physician, surgeon, physician's assistant, nurse practitioner, or certified nurse midwife, may certify to items 1 – 7, a licensed chiropractor may certify to items 5 – 7 items only, and a licensed physician or surgeon who specializes in diseases of the eye or a licensed optometrist may only certify to item 8.

My patient _____ meets the requirements of a disabled person found in CVC 295.5
(PRINTED NAME OF PATIENT)
as he or she suffers from the following:

- ☐ 1. A lung disease to the 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 60mm/Hg on room air while the person is at rest.
- ☐ 2. A cardiovascular disease to the extent that the person's functional limitations are classified in severity as class III or class IV based upon standards accepted by the American Heart Association.
- ☐ 3. A diagnosed disease or disorder which substantially impairs or interferes with mobility due to (*please print*):
  _____
- ☐ 4. A severe disability in which he or she is unable to move without the aid of an assistive device, which is due to (*please print*):
  _____
- ☐ 5. A significant limitation in the use of lower extremities due to (*please print*):
  _____
- ☐ 6. The loss, or the loss of the use of, one or more extremities. Loss of use due to (*please print*):
  _____
- ☐ 7. The loss, or the loss of the use of, both hands. Loss of use due to (*please print*):
  _____
- ☐ 8. Central visual acuity does not exceed 20/200 in the better eye, with corrective lenses, as measured by the Snellen test, or visual acuity that is greater than 20/200, but with a limitation in the field of vision such that the widest diameter of the visual field subtends an angle not greater than 20 degrees.

Authorized Medical Provider's Signature and Certification

PRINT AUTHORIZED MEDICAL PROVIDER'S LAST NAME	FIRST NAME	MI	AUTHORIZED MEDICAL PROVIDER'S DAYTIME PHONE #
			( )

AUTHORIZED MEDICAL PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

I certify that I am a **[ ] Physician [ ] Surgeon [ ] Chiropractor [ ] Optometrist [ ] Physician's Assistant [ ] Nurse Practitioner [ ] Certified Nurse Midwife** and certify (or declare) under penalty of perjury under laws of the State of California that the foregoing is true and correct. I also certify that I will retain information sufficient to substantiate this certification and shall make that information available for inspection by the Medical Board of California at the department's request. (CVC Section 22511.55).

EXECUTED AT (CITY, STATE)	DATE

AUTHORIZED MEDICAL PROVIDER'S SIGNATURE	MEDICAL LICENSE NUMBER

From California DMV Reg 195 (Rev. 8/2008) WWW