Disability Parking Permit Application

Access to the University of North Carolina at Chapel Hill for employees and students with disabilities is essential as it is for any member of the University community. The following application aids in providing reasonable accommodations for those who have a disability.

General Information

Eligibility

A disability is defined as:

"A substantial limitation (physical or mental) that is evident in more than one setting."
(American with Disabilities Act, 1990)

Parking Operations defines a disability (either permanent or temporary) as:

1. An obvious physical disability that requires the use of a wheelchair, braces, walkers or crutches.
2. Severely restricted mobility, as determined and certified by a physician due to, but not limited to, pulmonary or cardiovascular disability, an arthritic condition, orthopedic or neurological impairment.

Examples of conditions which do not normally require special parking privileges are: Normal pregnancy, asthma (exercise induced/seasonal), anemia, hypoglycemia, menstrual difficulties, allergies, migraine headaches, diabetes (without other complications), foot problems (such as plantar warts, calluses, bunions), hepatitis, mononucleosis (unless directed by physician), arthritis (without complications).

Please note that the above definitions and examples are intended as a guideline only. Consideration will also be given to post-surgical applicants as well as others as individual circumstances warrant. For assistance in determining eligibility, applicants should contact Parking Services (962.4424).

Services

Reasonable accommodations will include the use of campus disability spaces, campus transportation (***Point-to-Point***, the ***University Shuttle***, and ***UNC Hospital's shuttle buses***), and available public transportation (***Chapel Hill Transit*** and ***Triangle Transit Association***); additional time may be required to get to work or school.

Application Process

Applicants who need to park a vehicle on campus will be authorized parking privileges based on justification in the application completed and signed by a licensed physician (a physician unrelated to the applicant). The application will be reviewed at a monthly meeting of the University Disability Review Board (representatives from Disability Services, Student Health Services, and Parking Services). The applicant should also complete the **Authorization for Release of Confidential Information** form. Signing this form gives permission to a member of the review board to request additional information from the physician noted on your application. Upon request of the application, the applicant may be issued a temporary permit valid until the board reviews the application. The application should be returned to the University/Hospital parking office by the week before the next meeting of the review board.

Please note the following information:

- Mobility limitations cited on the physician's orders cannot exceed those noted as limitations affecting daily activity or job functions. These limitations cannot exceed those on file in the appropriate University/Hospital disability services office.
- Temporary disabilities (less than six months in duration) will be reviewed and considered on a space availability basis.
- Persons with permanent disabilities must be registered with the appropriate University/Hospital office:

Students
Jim Kessler
Director, Department of
Disability Services
CB 1500 Rm 5, Steele Building
919.962.8300 (voice/TTD)

Faculty/Staff (University)
Dr. Robert Cannon
EEO/ADA Officer
CB 9160, Pettigrew Hall
919.966.3576

Staff (Hospital)
Bonnie Overton
EEO/ADA Officer
CB 7600, East Wing
UNC Hospitals
919.966.0698

DISABILITY PARKING PERMIT APPLICATION

UNC-Chapel Hill, Department of Public Safety

This application aids in making appropriate parking accommodations for employees and students who are disabled*.

UNC employees and students applying for disability parking should return your completed application to Nancy Fearrington (voice -919.962.4424; fax -919.962.2572).

UNC Hospital employees return your completed form to Linda Hurysz (voice-919.966.0694; fax-919.966.0073).

*A disability is defined as physical or mental impairment that substantially affects one or more of such person's life activities.

(PLEASE PRINT ALL INFORMATION)

1. Applicant's Name: _____

2. Home Address: _____

Students, please provide your school address.

_____
City State Zip Code

3. Home Telephone: _____ Work Telephone: _____

4. Email Address: _____@_____

5. PID Number: _____

6. Please Check Status: ( )University Employee ( )Hospital Employee ( )Student/Year FR. SO JR. SR GRAD (circle one)

7. *Are you self identified with the University/Hospital as having a disability? ( ) Yes ( ) No

***For those applying for a permanent disability permit only**. Under the Americans with Disabilities Act you must identify with the University/Hospital as having a disability to be eligible for this accommodation.

8. Please list registered vehicles:

License Plate	State	Vehicle Make	Color
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. How do you currently get to work/school? _____
   If you travel by bus, which bus route do you use? _____

10. Do you currently have a UNC parking permit? YES NO If so, for what zone ?_____

11. Are you requesting a temporary or permanent disability permit? **temporary** (circle one) **permanent**

12. Physician's Name (must be an MD): _____
    Telephone Number: _____

For Office Use Only

Temporary Assignment: Zone: _____ Location Code _____ Expiration ____/_____/ 20___
Permit #_____ Does this application go to committee? Yes No (circle one)

University of North Carolina at Chapel Hill
Department of Public Safety

Public Safety Building, 205 Manning Drive, CB 1600, Chapel Hill, NC 27599-1600
(919) 962-3951 (voice) (919) 962-2572 (fax)

Complete this section if you are a University or Hospital Employee.

13. Department Name : _____

14. Department Function #: _____ Work Telephone: _____

15. Department Name (Please include Building Name) : _____

16. Work Hours: _____ Days of Week at Work: _____

Complete this section if you are a Student.

Please List Your Class Schedule.

CLASS _____ _____ _____ _____ _____

BUILDING _____ _____ _____ _____ _____

TIMES _____ _____ _____ _____ _____

PLEASE READ STUDENT HEALTH PARKING POLICY

STUDENTS MUST GO TO STUDENT HEALTH AND SEE DR. TUTTLE (966-6551)

This section is to be filled out by the applicant's PHYSICIAN.

17. **Please give specific diagnosis and specific findings of applicant's condition and please include ICD-9-CM Coding**.

ICD-9-CM _____ Condition_____

_____

ICD-9-CM _____ Condition_____

_____

ICD-9-CM _____ Condition_____

_____

Date of examination: _____

18. Identify limitations in mobility (limits in terms of time, distance, endurance, etc...)

_____

_____

_____

19. Please estimate distance applicant can independently travel using block, yards, etc._____

20. Are elevations/steps a problem for the applicant? _____

If yes, specify the number of steps the applicant a can perform. _____

21. Indicate if this is a temporary or permanent condition._____

    If temporary, how long will this condition last ?_____

22. Physician's Telephone Number : _____

23. Physician's Printed Name. _____

24. Physician's Signature: _____ Date _____

For Office Use Only

Date Application Reviewed: _____

Application Reviewed By: _____

Zone Approved: _____ Area/Location Approved: _____

Expiration Date of Permit: _____

Point To Point Card Approved: YES NO Date of Expiration: _____

Additional Comments: _____

_____

_____

_____

_____

Application Denied: _____ Date: _____

_____

_____

_____

_____

Committee's Comments: _____

_____

_____

_____

_____

_____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

In the event that information provided by the applicant's physician is not clear enough to address the applicant's parking needs, the Department of Public Safety Disability Parking Coordinator and/or members of the University's Disability Parking Review Committee request permission to contact the applicant's physician for clarification of the applicant's condition. The information provided would be and remain confidential, and it will not go beyond the confines of the committee evaluating the applicant's parking needs.

Applicant Name _____

Address _____

_____

Telephone Number **(Home)**_____
(Work) _____

Physician's Name _____

Physician's Address _____

_____

Physician's Telephone **(Voice)**_____
(Fax)_____

Applicant's Signature _____**Date** _____