Office of Student Disability Services
423 Wells Hall ■ Murray, KY 42071
Tel: (270) 809-2018 ■ Fax: (270) 809-4339
TDD: (270) 809-5889

ACCESSIBLE PARKING FORM

Application for an Accessible Parking Permit for a Student with a Disability

SECTION I- TO BE COMPLETED BY APPLICANT

Semester Applying for: ☐ Fall ___ ☐ Spring ___ ☐ Summer ___ M#: _____

Student Full Name: _____ SSN#:_____
Last First Middle Initial

Campus/Local Address _____
Street City State Zip

Campus/Local Telephone Number: _____

Home/Permanent Address: _____
Street City State Zip

Home Telephone Number: _____ Cell Number: _____

MSU E-mail Address_____ Alternate Email:_____

Classification: ☐ Entering Student ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Other:_____

I am requesting an accessible parking permit due to the following mobility problems and/or medical conditions:_____

_____

By signature below, applicant authorizes physician to complete Section II below, and to release information regarding medical condition. I understand that I can revoke this authorization at any time by submitting a written revocation. A revocation will not apply to information that has already been disclosed in reliance on an authorization. I understand that once the information is disclosed pursuant to this authorization it may be re-disclosed by the recipient and the information will no longer be protected by HIPAA. This authorization will expire six (6) months subsequent to the day executed as indicated below.

Signature of Applicant_____ Date _____

SECTION II- TO BE COMPLETED BY PHYSICIAN

1. Specific diagnosis of medical condition:_____

   _____

2. Date of injury or onset of illness or medical condition: _____
3. **Is condition permanent?** ☐ Yes ☐ No; **If no, how long will applicant be disabled**?

   _____

4. How does this disability or medical condition conform to attached criteria (**be specific**); see KRS 189.456(3) at bottom of next page:

   _____

   _____

Please return this completed form to the Office of Student Disability Services
Equal education and employment opportunities M/F/D, AA employer

SECTION II- TO BE COMPLETED BY PHYSICIAN/CONTINUED

5. Include or attach information on test results, surgeries, medication, or other information that supports this request (e.g. pulmonary function studies for asthma)

   _____

   _____

6. Does applicant require aids for walking, e.g., cane, walker, wheelchair, or other assisting device?
   ☐ No ☐ Yes, please specify _____

7. Other information or comments in support of this application for disabled parking (attach additional sheets if necessary)

   _____

   _____

   _____

Physician Name (please print) _____Phone: _____

Physician Address _____

Date _____Physician Signature _____

RETURN FORM TO:

Murray State University
Office of Student Disability Services
423 Wells Hall ■ Murray, KY 42071
Phone: (270) 809-2018 ■ TDD: (270) 809-5889 ■ Fax: (270) 809-4339

KENTUCKY REVISED STATUTE 189.456 (3)

(3) For every person seeking an accessible parking placard, proof of the disability shall be required by:

(c) A statement from a licensed physician that the applicant is a person whose mobility, flexibility, coordination, respiration, or perceptiveness is significantly reduced by a permanent disability to that person's arms, legs, lungs, heart, ears, or eyes.

KENTUCKY REVISED STATUTE 186.042 (1992)

For purposes of this section, "*persons with disabilities which limit or impair the ability to walk*" means persons who, as determined by a licensed physician:

- cannot walk two hundred (200) feet without stopping to rest;
- cannot walk without use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assisting device;
- are restricted by lung disease to the extent that the person's forced respiratory and expiratory volume for (1) second, when measured by spirometry, is less than (1) liter, or the arterial oxygen tension is less than (6) mm/hg on room air at rest;
- use portable oxygen;
- have a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association; or
- are severely limited in their ability to walk due to an arthritic, neurological, or orthopedic condition

APPEALS PROCESS

Any person seeking to appeal the decision of the Director of the Office of Student Disability Services must submit, in writing, a request to review the decision of the Director. This appeal must be delivered to the Office of Equal Opportunity, within five (5) working days of receipt of the Director of the Office of Student Disability Services' decision. The request shall state reasons why the party is requesting a review and may contain any information for consideration. The Director of Equal Opportunity will refer the appeal to the Affirmative Action Subcommittee on Disabilities. The committee may confirm, amend, or modify the decision of the Director of the Office of Student Disability Services. The decision of the committee shall be final.