

Office Use Only:

\_\_\_\_\_  
Permit #

\_\_\_\_\_  
\_\_\_\_\_  
By completing this form, you the practitioner are verifying that the following person legitimately qualifies for disability parking privileges. You are also certifying that this person is restricted in mobility due to a medical condition that has resulted in a functional limitation to mobility.

I certify that \_\_\_\_\_ is severely restricted in  
(Patient Name Please Print)  
mobility due to a physical disability, injury or other medical condition.

\_\_\_\_\_  
Practitioner Name (Please Print)

\_\_\_\_\_  
Practitioner Signature

\_\_\_\_\_  
Area of Specialty

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number of Practitioner

\_\_\_\_\_  
City & State

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAX OR MAIL TO:

University of Southern Indiana  
Parking  
8600 University Blvd.  
Evansville, IN 47712  
Fax: 812/465-1279  
Phone: 812/465-1091