Health Care Professional Statement

Applicant Name (Print): _____

Authorization for Release of Information

I give permission for the treating health care professional to provide information on the current limitations imposed by my disability or medical condition as it relates to this transportation accommodation request. Students may contact Campus Health Services at 919-966-2281 for assistance with this form.

Applicant's Signature: _____ Date: _____

Applicants issued disability placards by the state of North Carolina may provide the documentation used to support that application as part of this application. If the documentation does not address all of the issues listed below, the applicant should have their health care provider complete the additional information using this form.

Health Care Professional Section

This form should be completed by the treating Health Care professional (who is not related to the applicant) for the impairment or medical condition for the requested transportation accommodation. The health care professional must have the expertise to provide a diagnosis and the ability to speak about the current limitation imposed by the applicant's condition as it relates to this transportation accommodation request.

UNC campus has limited proximate parking, similar to an urban environment. Depending upon the applicant's primary campus locations, accommodations may include: a designated UNC-D campus disability space near the applicant's primary location, a designated UNC-D campus disability space that is more remote with intra-campus transportation provided, or accessible transit with proximate stop locations. On-demand accessible transit is available for intra-campus travel throughout the day.

Please ensure that this form includes sufficient detail to allow the Committee to provide a reasonable transportation accommodation.

Required Information:

- This mobility limitation is: ◯ Permanent or ◯ Temporary (Dates: From _____ To _____)
- Wheelchair / Mobility Scooter Required: ◯ Yes or ◯ No
- Distance: ◯ No Limit or ◯ Limit. Number of _____ Yards applicant can walk
- Elevation/Steps: ◯ No Limit or ◯ Limit. How many _____Steps _____ Flights applicant can climb

1. Provide a descriptive diagnosis and speak to the current functional limitations and the nature and severity of the disability and/or medical condition as it relates to this transportation accommodation request.

2. Can applicant use local or regional accessible public transit buses? ◯ Yes or ◯ No
   - If applicant is unable to use, please explain.

3. Can applicant use campus accessible mini-van service to accessible building entrances? ◯ Yes or ◯ No
   - If applicant is unable to use, please explain.

4. Are there specific activities, limitations, or aggravating conditions not listed above that the Committee should consider in providing the transportation accommodation?

Health Care Professional's Name (Printed): _____ Telephone: _____

Address:_____

City_____State _____Zip_____

Health Care Professional's Signature _____ Date _____