

Application for Designated Parking Space for Persons with Disabilities

Please read before completing application

To qualify for a designated parking space for persons with disabilities, applications will not be accepted without the entire application form completed by the employee and their physician.

All applications must be submitted through your Agency Mission Area Designee for Reasonable Accommodations. If you are a member of a carpool, you must also submit a completed Application for Parking Space Permit with this application.

All employees requesting a designated person with disabilities parking space are encouraged to join a car or vanpool. Pools with persons with disabilities receive extra credit to qualify for parking.

Please ensure your name appears on all of the pages of this application.

FALSIFYING INFORMATION ON THIS FORM OR THE APPLICATION FOR PARKING SPACE PERMIT IS FRAUD AND MAY RESULT IN THE LOSS OF PARKING PRIVILEGES FOR A MINIMUM OF ONE YEAR.

Application for Designated Parking Space for Persons with Disabilities

SECTION 1 – To be completed by Employee

NAME: Last _____ First _____

Agency: _____ Building: _____ Room: _____

Work Phone: (____) _____ Last 4 Digits of Social Security No.: _____

Please provide your work schedule below and indicate any days you telework and/or use Alternative Work Schedule (AWS) days off.

	First Week of Pay Period				
	Monday	Tuesday	Wednesday	Thursday	Friday
Work Hours					
	Second Week of Pay Period				
	Monday	Tuesday	Wednesday	Thursday	Friday
Work Hours					

Home Address: _____ City _____ State _____

Zip Code: _____ Do you live outside the Beltway? Yes _____ No _____

Make of Car _____ Model _____ License No. & State _____

Are you currently a member of a car/vanpool? _____ If so, where do you park? _____
 If not, would you consider joining one? _____ If not, why? _____

Are you requesting a temporary space (three months or less) _____ If yes, how long is the space needed? _____. If no, when does your handicapped tag/permit expire: _____

Can you park in a regular size parking space? _____ If no, indicate why (such as wheelchair or motorized cart)? _____

I certify that if my permanent medical condition's (with no ending date) limitations change, improve, or are eliminated, I understand that I am required to submit an updated parking application for the agency's review to determine whether the disabled parking pass is still appropriate.

Applicant's signature: _____ Date: _____

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SECTION 2 – To be completed by Physician

NAME: Last _____ First _____

Part A: Duration of Medical Condition

Temporary _____ Permanent (including intermittent) _____

For temporary medical condition, please provide start and end dates. (A temporary medical condition may extend beyond a proposed end date. In this case, medical documentation substantiating medical condition and need for extended temporary parking must be submitted ten days before original proposed end date expires and every month thereafter.)

____/____/____ through ____/____/____
mm dd yy mm dd yy

What is the duration of the employee’s medical condition (please provide an estimate if unknown)

Part B. The Employee

- _____ 1) Has a cardiac condition to the extent that the applicant’s functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association.
- _____ 2) Uses portable oxygen.
- _____ 3) Has an arterial oxygen tension (PAO2) of less than 60mm/Hg on room air at rest.
- _____ 4) Is restricted by a respiratory disease to such an extent that the applicant’s forced (respiratory) expiratory volume for one measured by spirometry, is less than one liter.
- _____ 5) Has lost an arm or leg and does not have or cannot use an artificial limb.
- _____ 6) Due to medical condition, uses a wheelchair or cannot walk without the aid of another person, a walker, a cane, crutches, braces, a prosthetic device, or another assistive device. Please explain:

- _____ 7) Has a medical condition that would be aggravated by walking 200 feet under normal environmental conditions to an extent that would be a significant risk to self.

What distance can the employee walk without significant difficulty? _____

How significant is the difficulty in walking? Please use the scale below.

Low Medium High
1 2 3 4 5 Please explain _____

SECTION 2 Continued – To be completed by Physician

NAME: Last _____ First _____

_____ 8) Due to medical condition, cannot walk 200 feet without stopping to rest.

What distance can the employee walk without significant difficulty? _____

How significant is the difficulty in walking? Please use the scale below.

Low Medium High
1 2 3 4 5 Please explain _____

_____ 9) Due to medical condition cannot walk without a significant risk of falling.

_____ 10) Has a specific medical condition related to pregnancy that could be aggravated by walking to the extent that the life or health of the person or fetus may be endangered. (Temporary only; may not exceed expected length of pregnancy.) Describe condition _____

Low Medium High
1 2 3 4 5 Please explain _____

_____ 11) Has a temporary need or traumatic injury. Is the accessible parking pass needed because of a break, sprain or other temporary condition? Yes _____ No _____ If yes, was surgery performed? Yes _____ No _____. What was the surgery for? _____
_____. What was the date of the surgery _____
What is the expected date of recovery? _____ (month/day/year).

How significant is the difficulty in walking? Please use the scale below.

Low Medium High
1 2 3 4 5 Please explain _____

_____ 12) Other. Please explain _____

SECTION 2 Continued – To be completed by Physician

NAME: Last _____ First _____

Is the employee substantially limited to the point that it would be unreasonably difficult or impossible for him/her to take public transportation? Yes _____ No _____

Please explain: _____

Is the employee substantially limited to the point that it would be unreasonably difficult or impossible for him/her to be a member of a car or vanpool? Yes _____ No _____

Please explain: _____

Other comments or information: _____

Part C: Physician's Contact Name, Signature, Date, and Contact Information

Physician's Name: _____ Signature: _____ Date: _____

Physician's Address: _____

Physician's Phone Number: _____

USDA MISSION AREA DESIGNEES FOR REASONABLE ACCOMMODATIONS

MISSION AREA/AGENCY	CONTACT	ADDRESS	PHONE NO.
DA	Samantha Owens	Rm. 17-W Whitten	(202) 720-3263
OCFO	Patricia Bachemin	NFC	(504) 426-6206 Fax (504) 426-9710
MRP (AMS, APHIS, GIPSA)	Kimberly Meyer-Chambers	Unit 158, 3B,03,15 4700 River Road Riverdale, MD	(301) 734-7489 Fax (301) 734-6353
REE (ARS, ERS, NASS, CSREES)	Mary Ward	Rm. 3913-South Bldg.	(202) 690-0372 Fax (202) 690-0109
FFAS	Nicole White	1280 Maryland Ave., SW Suite 490 Washington, DC	(202) 401-0571 Fax 202) 205-9064
FNS	Anita Cunningham	3101 Park Center Drive Rm. 942 Alexandria, VA	(703) 305-0986 Fax (703) 305-2832
FSIS	Brandy Pelham	Rm. 3815-South Bldg.	(202) 720-3873 Fax (202) 690-1666
FS	Tom Valluzzi	201 14 th Street Rm. 4 SW, Yates Bldg.	(202) 205-1062 Fax (202) 690-1025
NRCS	Cliff Denshire	5601 Sunnyside Ave. Rm. 1-1144C Beltsville, MD	(301) 504-2332 Fax (301) 504-2175
RD	Marjorie Beverly	Rm. 1330-South Bldg.	(202) 692-0176