

**PARKING VERIFICATION FORM**  
**UCLA Office for Students with Disabilities**  
**(310) 825-1501 (310) 825-9656 fax**

\_\_\_\_\_ is requesting parking at UCLA based on a disability or medical condition. Please respond to the following questions so that the OSD can have a complete application for this student.

Diagnosis \_\_\_\_\_ Diagnosis date \_\_\_\_\_

Please state severity of disability \_\_\_\_\_

Please list procedures/assessments used to reach diagnosis \_\_\_\_\_

**Probable duration of disability:**

Up to 4 weeks     3 months     6 months     1 year     chronic

**Functional Limitations**

Walking distance capability \_\_\_\_\_ How many flights of stairs can student use daily? \_\_\_\_\_

How much fatigue, if any, does student encounter? \_\_\_\_\_

Is there shortness of breath (please specify severity)? \_\_\_\_\_

What assistive devices are needed? \_\_\_\_\_

Other \_\_\_\_\_

How would the student's health be jeopardized if parking arrangements were not approved?

\_\_\_\_\_  
\_\_\_\_\_

Is student able to ride a bus? \_\_\_\_\_ Does student qualify for a handicapped placard? \_\_\_\_\_

If so, why doesn't student have placard? \_\_\_\_\_

Is this student currently receiving therapy or regular check-ups? \_\_\_\_\_

If so, what is the frequency and expected duration? \_\_\_\_\_

**I certify that this information is current and accurate for the above-named patient.**

Medical Professional's Signature \_\_\_\_\_

Type or print name \_\_\_\_\_ License \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_