Submit the completed form to Office of Compliance at oc-hsc@uthsc.edu or fax (901) 448.1120

Please follow the application requirements listed here https://uthsc.edu/campus-police/parking-and-access/accessible-parking.php

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

APPLICATION FOR ACCESSIBLE PARKING

*Required Information

Personal Information*

APPLICATION MUST BE COMPLETED IN THE NAME OF THE APPLICANT.

PLEASE COMPLETE ALL INFORMATION.

_____ Personnel # or Student ID#

_____ Driver's License #

_____ Full Name

_____ College or Department

_____ Address 1

_____ Address 2

_____ City

_____ State

_____ ZIP Code

_____ DOB: mm/dd/yyyy

_____ Phone Number (xxx) xxx-xxxx

Vehicle Information*

_____ Year

_____ Make of Vehicle

_____ Tag Number and State

_____ Color

☐ Owner (you own the title)

☐ Driver (owned by another)

Permit Information*

_____ Current Parking Lot

_____ Requested Parking Lot(s)

☐ One-Year Permit (submit a picture of a State-issued Disabled Plate/Placard)
☐ Temporary Permit _____ months (up to 6 months)

I, the applicant for the permit, hereby certify, under the penalties prescribed in Tenn. Code Ann. § 55-21-102, that the statements made herein are true and correct to the best of my knowledge, information, and belief. "Permit is only valid for parking areas owned or leased by The University of Tennessee Health Science Center. The permit is not valid for city streets or other areas not controlled by the university."

Applicant's Signature*_____ Date*_____

Office of Compliance Use Only – Medical Certificate Verification

_____ Approved By

_____ Date Approved

Parking Services Office Use Only

_____ Approved By

_____ Date Approved

_____ Permit # Assigned

_____ Expiration Date

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER.

COMPLIANCE

APPLICATION FOR ACCESSIBLE PARKING- CERTIFICATION OF DISABILITY

The section below must be completed by a medical doctor licensed to practice medicine (MD), a Christian Science Practitioner listed in the Christian Science Journal, nurse practitioner (APRN), licensed physical therapists (PT), licensed chiropractic physician(DC), or physician's assistant (PA).

The completed form can be sent to oc-hsc@uthsc.edu or faxed to (901) 448-1120. This certificate must be resubmitted with each new accessible parking application.

Tenn. Code Ann. § 55-21-102 (3)

(A) "Disabled driver" is one who is disabled by paraplegia, amputation of leg, foot or both hands, or is disabled by loss of use of a leg, foot or both hands, or other condition, certified to by a physician duly licensed to practice medicine, resulting in an equal degree of disability (specifying the particular condition) so as not to be able to get about without great difficulty, including impairments that, regardless of cause or manifestation, require the use of a wheelchair or cause the person to be so ambulatorily disabled that the person cannot walk two hundred feet (200′) without stopping to rest and includes, but is not limited to, those persons using braces or crutches and those with pulmonary or cardiac ills who may be semiambulatory;

(B) "Disabled driver" also includes the owner of a motor vehicle with vision of not less than 20/200 with correcting glasses in both functioning eyes;

(C) "Disabled driver" also includes the owner of a motor vehicle who is so ambulatorily disabled that the person cannot walk two hundred feet (200′) without stopping to rest and who is seeking treatment and/or healing solely by prayer through spiritual means in the practice of religion in accordance with the creeds or tenets of the First Church of Christ, Scientist in Boston, Massachusetts. The condition shall be certified by a Christian Science practitioner listed in The Christian Science Journal as resulting in a degree of disability so that the person is not able to get about without great difficulty;

Patient Name: _____

Is the applicant using a wheelchair for permanent incapacity for ambulation? YES ☐ NO ☐

Mechanical device used: Crutches ☐ Braces ☐ Other _____

Nature of the disability: _____

Length of disability: Permanent ☐ Temporary ☐ _____ months

Provider Details (MD/Christian Science Practitioner/APRN/PT/DC/PA)

Name: _____

Clinic's Name & Address _____

City _____ State _____ Zip Code _____ Phone _____

I hereby certify that the applicant named in this application has appeared before me and, in my medical opinion, that they meet the requirements for Tenn. Code Ann. § 55-21-102 (3).

Provider's Signature _____ Date _____

Office of Compliance Use Only– Medical Certificate Verification

_____ _____

Approved By Date Approved