DHMH MEDICAL PARKING APPLICATION

☐ Temporary ☐ Permanent

Employee Name _____**Telephone**_____

DHMH Unit_____ **Grade** _____ **EOD** _____

THE FOLLOWING TO BE COMPLETED BY A LICENSED PHYSICIAN

Medical Certification:
I, the undersigned physician, hereby certify that the person named above on this application has appeared before me for medical evaluation, and in my medical opinion, has the conditions that are described below.

Printed Name _____**Phone**_____

Signature _____ **Date** _____

Address _____

Medical License # _____ **State** _____ **Exp Date** _____

INSTRUCTIONS: PLEASE CHECK ALL THAT APPLY- UNMARKED ITEMS MAY DISQUALIFY APPLICANT.

Criteria for Consideration of a Medical Parking Permit

[SCORING CRITERIA:ITEMS 1, 2, AND (3 OR 4) ARE PRIMARY REQUIREMENTS]

___1. Applicant has a disability, condition, or injury limiting mobility that is:
___permanent.
___temporary. (Estimated duration)_____

___2. Applicant is unable to walk 200 feet without assistance and without stopping to rest.

___3. Applicant is unable to walk alone without assistance of a mechanical device or another person.

___4. Applicant requires a wheelchair or mechanical device for mobility.

___5. Applicant requires the use of the following mechanical device for mobility.

___Crutches	**___all of the time**	**___some of the time**
___Braces	**___all of the time**	**___some of the time**
___Wheel Chair	**___all of the time**	**___some of the time**
___Prosthesis	**___all of the time**	**___some of the time**
___Other	**___all of the time**	**___some of the time**

(specify) _____

___6. Applicant has a condition that substantially impairs mobility and which is so severe that the person's health would be adversely affected if the individual had to walk more than 200 feet. The adverse health effect would be:
___ further injury
___ possible respiratory failure
___ possible cardiovascular failure
___ premature labor
___ other (specify) _____

___7. Applicant has lung disease to such an extent that he or she is always breathless
___at rest.
___on minimal exertion.
___on light exertion.

___8. Applicant has lung disease to such an extent that his/her forced expiratory volume in one second, when measured by spirometry is always less than:
___one liter.
___two liters.

___9. Applicant has permanent loss of use of:
___one leg
___both legs

DIAGNOSIS:
IN SUPPORT OF THE ABOVE CHECKED CRITERIA, THE PHYSICIAN IS TO PROVIDE A PERTINENT DIAGNOSIS WITH A WRITTEN DESCRIPTION OF HOW THE APPLICANT'S MOBILITY IS IMPAIRED.

Please Note: If necessary, medical parking allocations shall be prioritized by a consulting physician based on the severity of the disability with one being the highest priority, two or three being lower priorities. At anytime, your medical permit can/will be allocated to another with a higher priority.

Physician must FAX this application under cover sheet DHMH 4576-4) to DHMH Parking Coordinator, 410 333-7482 or mail copy to:
DHMH Parking Coordinator, 201 West Preston Street, Rm LL-4, Baltimore MD 21201-2301

For Official Use Only:

Allocation Number_____ Date Issued: _____Location: ___Lot ___Garage

DHMH 4576-1 (Revised-4/2012) Previous Form Obsolete