STANFORD UNIVERSITY PARKING & TRANSPORTATION SERVICES

MEDICAL CERTIFICATION FOR MOTORIZED CART PERMIT

ONLY ORIGINAL SIGNATURES WILL BE ACCEPTED. NO FAXES OR PHOTOCOPIES. ANY ALTERATIONS, CROSSOVERS, OR WHITEOUT WILL VOID THIS FORM.

DOCTOR'S CERTIFICATION OF DISABILITY (Please print legibly)

Print the name of student with disability: _____

Check the appropriate box and describe disability below

☐ A diagnosed disease or disorder which substantially impairs or interferes with mobility due to:

☐ A severe disability in which he or she is unable to move without the aid of an assistive device, which is due to:

☐ A significant limitation in the use of lower extremities due to:

Provide a full description of the illness or disability: _____

_____

_____

_____

AUTHORIZED MEDICAL PROVIDER'S INFORMATION AND SIGNATURE (Complete ALL fields)

Print name (Last, First, Middle)		Daytime telephone #
Address	City	State Zip code
I certify that I am a: ☐ Physician ☐ Surgeon ☐ Chiropractor ☐ Physician Assistant ☐ Nurse Practitioner		Medical license #
Signature		Date

SELECT AN APPROPRIATE CART PERMIT

☐ Annual "Cart" permit (expires 10/31/12)

☐ Temporary/Monthly "Cart" permit (enter expiration date – no later than 10/31/12): _____ / _____ / _____

THIS SECTION TO BE COMPLETED BY STUDENT (Please print legibly)

Name	Stanford ID #
Email address	Mobile phone #

I declare that I have been diagnosed with a disability that substantially impairs or interferes with my mobility thereby requiring the use of a golf cart on campus. I understand that falsifying information, allowing others to operate my cart without me as a passenger, or violating other cart rules and regulations (see Disability Cart Permit Agreement) may result in suspension of my cart operating privileges and/or administrative disciplinary action.

X _____ _____

SIGNATURE DATE

P&TS witness:

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Revised 1/12

Mail: 340 Bonair Siding, Stanford CA 94305-7255 MC: 7255 Email: parkingoperations@stanford.edu Phone: 650.723.9362 Fax: 650.724.8676

transportation.stanford.edu