Kentucky Finance and Administration Cabinet version 1.1
Division of Real Properties
Reserved ADA Parking Application

Special parking privileges may be given to qualified persons upon completion and approval of this application. Incomplete forms or substitute forms will not be accepted. If appropriate, a temporary parking permit can be provided during the application process. Do not hesitate to contact ADA Coordinator (502-564-2205) if you need assistance. **Fax completed application to ADA Coordinator, 502-564-8108.**

The **applicant** must complete **SECTION 1** and the applicant's **physician** complete **SECTION 2**.

Section I….Completed by Applicant

Name:_____ Date of Request ____/ ____/ ____

Agency_____ Building Name: _____

Email Address: _____ Work Phone:(____) ___ -_____ ext ___

By signature, the applicant attests that he/she has a physical or mental impairment that substantially limits his/her mobility, this impairment conforms to KRS 186.042, and the information provided is correct and factual.

Signature of Applicant: _____ Date: ___ / ___ /___

Section II Completed by Physician

I have treated the above applicant and attest they have a physical or mental impairment that substantially limits their mobility and this impairment conforms to KRS 186.042 .

Please check one. (KRS 186.042)

___ cannot walk 200 feet without stopping to rest;

___ cannot walk without assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair or other assisting device;

___ are restricted by lung disease to the extent that the person's forced respiratory volume for (1) second, when measures by spirometry, is less than (1) liter, or the arterial oxygen tension is less than (6) mm/hg on room air at rest;

___ use portable oxygen;

___ have a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association; or

___ are severely limited in their ability to walk due to an arthritic, neurological, or orthopedic condition.

Disability: _____

_____

This impairment is ___ permanent ___ temporary. If temporary how long? _____

Comments:_____

Physicians Name (please print): _____ Phone: _____

Physicians Signature: _____ _____ Date: ____ /____ / ____