

REQUEST FOR ADA ACCESSIBLE PARKING PERMIT

NAME OF EMPLOYEE

AGENCY

MAILING ADDRESS

WORK PHONE NUMBER

DATE OF REQUEST

Please state below a short description of the disability:

State below the exact timeframe which you are requesting an ADA Parking Permit:

List below the name of your physician and phone number who is recommending you obtain an ADA Parking Permit:

Comments:

REMINDER:

Send this application and your doctor's statement to:

**Greg Slattery
Finance and Administration Cabinet
Department for Facilities Management
Division of Real Properties
403 Wapping Street
Frankfort, KY 40601
502-564-5490 Ext. 231
Fax 502-564-8108**

This document was created with Win2PDF available at <http://www.win2pdf.com>.
The unregistered version of Win2PDF is for evaluation or non-commercial use only.
This page will not be added after purchasing Win2PDF.