PHYSICIAN'S STATEMENT MUST BE PRINTED OR TYPED

Policy Statement – A reserved parking space in front of a residence is a special privilege granted by the Borough of Tamaqua, only to people who have severe physical disabilities. Such space will only be granted to those who cannot manage without it.

Patients Name:_____ Age:_____

1. Please indicate the patients diagnosis:_____
_____

2. Please describe in detail why you feel applicant should have reserved handicap parking:
_____
_____

3. If the applicant's diagnosis is heart disease, please check the below classification:

( ) Class I Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpation, dyspnea, or angina pain.

( ) Class II Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpation, dyspnea, or angina pain.

( ) Class III Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity. Causes fatigue, palpitation, or angina pain.

( ) Class IV Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the angina syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

4. Is the patient restricted by lung disease? Yes ( ) No ( )

a. If yes, is patient restricted to the extent that the patient's forced (respiratory) Expiratory volume for one second when measured by spirometry, is less than One liter or the arterial oxygen tension is less than 60 mm/hg on room air at Rest? ( ) Yes ( ) No

b. Uses portable oxygen? ( ) Yes ( ) No

5. Can the applicant walk more than 200 feet without stopping to rest? ( ) Yes ( ) No

6. Is the patient's disability permanent? ( ) Yes ( ) No If no, what is the patient's prognosis for recovery?_____
_____
_____

7. Does the patient drive a motor vehicle? ( ) Yes ( ) No

8. Can the patient walk up or down steps without difficulty? ( ) Yes ( ) No

9. Does the patient walk with the assistance of a cane, crutch, prosthetic devise, brace or other assistance device? ( ) Yes ( ) No

COMMENTS: _____
_____
_____
Physician's Name:_____
Address:_____ Phone #:_____

Physician's Signature:_____ Date:_____