

Acknowledgement Form for Medical Parking Applicants

NOTE

This form is to be submitted to the DHMH Parking Coordinator with copies of the applicant's:

- MVA Disability Parking Certification Card;
- vehicle registration card; and/or
- Parking placard (red or blue).

My Disability is:

TEMPORARY;

PERMANENT;

OR I am a DHMH employee who is a transporter of a disabled DHMH employee.

Last Name

First Name

MI

DHMH Unit- Office, Administration, Division, etc.

Work Phone

____/____/____
Date of Birth

SSN (last four digits)

ID Card No. Front

ID Card No. Back

Make of Vehicle

Model of Vehicle

Year of Vehicle

License Tag No. w /State

ACKNOWLEDGEMENT STATEMENT

I understand that the medical parking privilege is provided for the purpose of accommodating the disabilities resulting from an employee's medical condition, and is contingent upon documented medical certification of this condition. I understand that if any data provided by me or my doctor is found to be false or deceptive, or if any of the documents submitted have been altered or falsified, that I will be subject to the sanctions of applicable laws, regulations, and policies including civil and criminal actions, employment disciplinary actions, and loss of parking privileges. By signing this statement, I acknowledge that I have read the DHMH Parking Policy and understand the requirements and obligations of the medical parking program.

Signature

Date