Medical Verification for SafeRide Disability Transport

Name ______________________ **ID# 800** ____________ **Date** ____________

Campus/Home Phone ______________ **Campus Department** ____________________

Campus Address ____

Campus Email ______________________ **Status** ❒ STUDENT ❒ EMPLOYEE ❒ OTHER

I request SafeRide Disability Transport services due to the following mobility impairments and/or medical conditions:

With this signature I authorize my physician to complete the information below about my medical condition and return the form to the Office of Disability Services of UNC Charlotte.

Signature of Applicant ______________________________ **Date** ____________

Physician – This information is being provided to support the need for on-campus transportation services for the above individual. Please comprehensively complete ALL items shown below.

1. Specific diagnosis______________________ **2. Is condition permanent?** ❒ **YES** ❒ **NO**

3. Date of injury/onset of illness/condition ______________________ **4. Duration of condition** ____________

5. How does this condition impair mobility? (Be specific) ______________________________

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Physician Name (Please print) ______________________ **Phone** ____________

Physician Address ____

Physician Signature ______________________________ **Date** ____________

Return form to:
UNC Charlotte Office of Disability Services
9201 University City Boulevard
Charlotte, NC 28223-0001

Phone 704-687-0040 **Fax 704-687-1395**