



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 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) _____

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 704-687-4355 Fax 704-687-3226