Handicap Parking Request

Use prescribed by NIH Manual Chapter 1410

Instructions

1. Include pertinent medical facts about yourself, including a brief medical summary from your physician (in Parts A and B). This does not ensure a preferential space.

2. Send this form to Occupational Medical Service (OMS), in Building 10, Room 6C306 or fax to 301-402-0673. The phone number for OMS is 301-496-4411. The Medical Director will consider all information and provide a recommendation to the Division of Amenities and Transportation Services (DATS).

3. IMPORTANT NOTE: **OMS can not recommend approval for more than 90 days on a handicap parking request.** If you anticipate that the need for handicap parking will exceed 90 days, contact your state Division of Motor Vehicles (DMV) for information on applying for disability license plates/placards (see Manual Chapter 1410: Parking, F. (Procedures), 4 c. ii.).

4. OMS will contact you if it is unable to recommend approval of your request.

Privacy Act Notification Statement: Collection of this information is authorized under 5 U.S.C. 7901. The primary use of this information is to justify the need for a handicap parking permit at the National Institutes of Health. This information may be disclosed to NIH staff in Occupational Medical Service for the purpose of considering the information, to NIH staff in the Division of Amenities and Transportation Services, to staff in the applicable Division of Motor Vehicles regarding the application of a disability license plate/placard, to HHS personnel offices for determination of fitness for duty, for disability retirement and other separation actions, and to monitor personnel to assure that safety standards are maintained. Submission of this information is voluntary; however, in order for us to consider your request for a handicap parking permit, you should complete all fields.

Part A *To be completed* *by* **Employee**	Employee's Name *(please print)*	IC	Building/Room	Phone No.
	Fax No.	Social Security No. *(last 4 digits only)*	Have you ever been to OMS? ☐ Yes ☐ No	If "yes," date of last visit
	Explain your need for a handicap permit			

Part B *To be completed* *by* **Employee's** **Physician**	Date of last physical examination for this patient	Estimated duration of need for handicap parking	Diagnosis
	Current treatment		
	Signature	Date	Phone No.

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Handicap Parking Recommendation

Part C *To be completed by* **OMS** *and sent to* **ORS's Division of Amenities and Transportation Service**	Employee's Name *(please print)*	IC	Building/Room	Phone No.
	☐ OMS recommends *limited* handicap parking from _____ to _____ Is this a renewal? ☐ Yes ☐ No ☐ OMS *does not* recommend handicap parking.			
	Comments *(if any)*			
	Signature		Date	

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