MONTGOMERY TOWNSHIP POLICE DEPARTMENT

J. Scott Bendig
Chief of Police

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215-362-2301 • Fax 215-362-6383

Application: Physician Certification of Disability

Instructions:

- All portions of this form are to be completed by the applicant's treating physician, based upon an examination completed within the past six months.
- Applicant agrees that a reserved residential parking space is a privilege granted by Montgomery Township and is granted to those persons who have severe physical disabilities and who are mobility impaired to such a degree that they cannot manage without it.

Patient Information

Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Patient's Age: ____ Phone: _____ Date of Examination: _____

Disability Status

Check all that apply:

- Non-ambulatory (wheelchair required): ☐
- Impaired or assisted ambulation (extreme difficulty walking requiring the use of a walker or similar type device): ☐
- Arthritic condition (where condition makes walking difficult): ☐
- Amputation or anatomical deformity (where walking is due to amputation or congenital deformity of the lower extremity): ☐
- Cerebrovascular accident (stroke/brain injury): ☐

- Pulmonary disability (difficulty walking due to a respiratory condition): ☐
- Cardiovascular disease (due to cardiac ills, has extreme difficulty walking): ☐
- Neurological disabilities (restricted mobility due to impairment of the central nervous system): ☐
- Other type of disability (specify): _____

Please specify date of onset of disability: _____

Please specify in detail the nature and extent of the patient's disability:

_____

_____

I performed the following test(s) and/or procedures in diagnosing the patient's disability:

_____

_____

Please specify the diagnosis and prognosis of the patient:

_____

_____

Will the patient's disability:

improve____ remain the same _____ deteriorate ____

Please state the current physical condition of the patient:

_____

_____

Does the patient require the use of any of the following mobility devices?

wheelchair ___ crutches ___ scooter ___ cane ___ walker ___ braces ___

other (please specify):_____

Does the patient require assistance entering or exiting a vehicle?

_____

Does the patient require assistance entering or exiting their home?

_____

Is the patient capable of driving? ___

Applicant Certification

I certify that the information contained herein is true and correct to the best of my knowledge and belief. I understand that any false statement(s) made herein are subject to the penalties of 18 PA C.S. #4904, relating to unsworn falsification to authorities.

_____	_____	_____
Physician's Printed Name	Physician's Signature	Date

_____

Address

_____	_____
Phone Number	Medical License Number

I am a board-certified physician in the following areas:

_____

_____