Parking and Transportation Services
Verification of Permanent Mobility Impairment

COLORADO STATE UNIVERSITY

Today's Date:_____ CSU ID Number: _____

Parking and Transportation Services provides on-campus transportation to enrolled students with a permanent disability that limits mobility due to a medical condition(s). Participants with an ambulatory disability are required to have this form completed by their attending medical provider. Please return completed form by email to courtesyshuttle@colostate.edu. Services will suspended if the form is not complete and/or not returned to Parking and Transportation Services.

I, _____, give permission for my medical provider to release relevant medical information to Parking and Transportation Services at Colorado State University to determine eligibility and available seating for a courtesy shuttle trip(s) during operating hours between classes on the main campus along with CSU on-campus student housing. Please contact me should you have any questions about this application at my **phone**: _____ or **email**: _____ .

Patient Signature: _____ Date: _____
Parent/Guardian Signature (if patient under 18)_____ Date: _____

TO BE COMPLETED BY MEDICAL PROVIDER

Your Patient has requested transportation services on the basis of a medical condition that significantly impacts their ability to walk. It is necessary to complete the following information to determine eligibility for a courtesy shuttle on our campus based on the determination of a permanent disability. Information provided will remain confidential and will not be shared with anyone.

A. Briefly describe disability: _____
B. Is the disability permanent in nature? YES ☐ NO ☐
C. Patient is capable of walking a maximum walking distance of _____ feet
D. Does the patient require a mobility device or walking aid: YES ☐ NO ☐ What device?

MEDICAL PROVIDER INFORMATION

Is this medical evaluation being completed by the CSU Health and Medical Center***? YES ☐ NO ☐
Is this medical evaluation an appeal / second opinion for this patient? YES ☐ NO ☐
Medical Provider's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Office Phone: _____ Fax: _____
Comments:

Medical Provider Signature:_____ Date: _____

****A "Transportation Consult" can be scheduled with the CSU Health and Medical Center at 970-491-7121.*