TEMPORARY DISABILITY PERMIT REQUEST FORM

DEFINITION: PERSON WITH DISABILITY ILLINOIS COMPLIED STATUTES 625 ILCS 5/1-159.1

A natural person who, as determined by a licensed physician: (Check all that apply)
_____ 1) cannot walk 200 feet without stopping to rest;
_____ 2) cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistive device;
_____ 3) is restricted by lung disease to such an extent that his or her forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 mm/hg on room air at rest;
_____ 4) uses portable oxygen;
_____ 5) has a cardiac condition to the extent that the person’s functional limitations are classified in severity as Class III or Class IV, according to standards set by the American Heart Association;
_____ 6) is severely limited in the person’s ability to walk due to arthritic, neuroglial or orthopedic condition.

THIS SECTION TO BE FILLED OUT BY PHYSICIAN

Patient’s Name _____________________________________________________________________________________

Patient’s Condition and Diagnosis ____________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Estimated length of disability in days (maximum 45 days) ____________

I hereby certify that the physical condition of the person with disabilities named above constitutes him or her as a person with disabilities as described under Illinois Complied Statutes 625 ILCS 5/1 – 159.1.

Physician’s Signature ___________________________________ Physician’s License # ___________________________

Physician’s Name (please print) ________________________________________________________________________

Address __________________________________ City ______________________ State _____________ Zip ______

Phone with Area Code ___________________________________________

THIS SECTION TO BE FILLED OUT BY JOLIET JUNIOR COLLEGE POLICE DEPARTMENT

Permit Number ___________________________ Issued Date ______________________ EXP Date _______________________

Vehicle Information: Make ___________________ Model ___________________ Color ___________________________

Plate Number ________________________ Phone Number __________________ Email _____________________________

Send from via E-mail to cprecords@jjc.edu, or deliver to Campus Police G1024