

PERMANENT SEAT LICENSE DISABILITY NEEDS FORM
Information Requested

PSL Holder: _____

Person with Disability: _____ Relationship: _____

Description of needs/disability (please be as detailed as possible):

Description of functional limitation:

- Mobility *[specify below]* Vision *[specify below]*
 Hearing *[specify below]* Other *[specify below]*

Is a mobility device (wheelchair, cane, walker, etc.) needed?

- Yes *[specify]* _____ No

Is condition permanent? Permanent Less than 60 days 60 days or longer *[specify]*

Is condition severe? Mild Moderate Severe

Is an accommodation requested? No Yes *[If yes, specify below]*

- Accessible seat Service animal Other *[specify below]*
 Companion seat Assistive listening

Please specify the preferred seating arrangement for this disability:

- Space for a wheelchair – Number of wheelchairs _____
 Stadium chair (installed purple chair) – Number of stadium chairs _____
 Stacker chair (movable plastic chair without arms) – Number of stackers _____

Additional comments:

Signature of Certifying Professional

License Number

Date

Name (print)

Address

Phone