

AUTHORIZATION FOR USE OF FIRST-CLASS OR PREMIUM-CLASS OTHER THAN FIRST-CLASS
(PCotFC) TRAVEL ACCOMMODATIONS

FOR EMPLOYEES WITH DISABILITIES OR OTHER SPECIAL NEEDS

First Class¹

PCotFC

(Please check authorization requested)

NAME OF EMPLOYEE:

ORGANIZATION:

NATURE OF DISABILITY OR SPECIAL NEED:

CERTIFICATION: I CERTIFY THAT I AM DISABLED OR OTHERWISE REQUIRE SPECIAL NEEDS SUCH THAT OTHER THAN FIRST-CLASS/PCotFC ACCOMMODATIONS CANNOT BE USED.

Signature of Employee

Date

SIGNATURE OF COMPETENT MEDICAL AUTHORITY:

AUTHORIZED BY: _____

TITLE: _____

DATE: _____

THIS AUTHORITY WILL EXPIRE AT EITHER SIX OR TWELVE MONTHS FROM DATE OF APPROVAL DEPENDING UPON NATURE OF DISABILITY OR SPECIAL NEED (See NIH MANUAL 1500 CHAPTER 13-00 (D)(1)).

¹If First-Class accommodations are requested, please provide specific medical reason why PCotFC accommodations cannot be used. If no reason is given, only PCotFC will be authorized.