Instructions:

Please fully read the Request Process & Important Information before submitting your Medical Parking Permit Request.

Request Process:

1. Student is to complete and submit Parts 1a + 2 to Student Health Services.
2. Student is also responsible for having his/her treating provider complete and submit Part 3 to Student Health Services.
3. The final Parking Waiver Recommendation (Part 1b) will be completed within 4 business days upon receipt of Parts 1, 2 & 3. *We will not be able to fully process a request until we receive Part 3, which again, is to be completed by the student’s medical provider.*
4. Once the final recommendation has been completed, the student and Parking and Transportation Services will be notified via UVM e-mail.

Important Information:

1. Receipt of an emergency temporary handicap parking permit from parking and transportation does not guarantee a handicap permit.
2. If granted a temporary on-campus permit, the student is responsible for associated fees.
3. Transportation to/from medical appointments, illness (personal, family, or friends) will not be accepted as a basis for granting a waiver.
4. Temporary parking for medical necessity can be granted for a maximum of 8 weeks.
5. Individuals with short term disabilities who anticipate their condition to continue for longer than thirty days are expected to apply to the State of Vermont, Department of Motor Vehicles for the appropriate disabled parking placard. Please refer to the Transportation & Parking Services web site www.uvm.edu/tps for more information.
Part I

Please fax (802) 656-8178, e-mail: CHWBMIF@uvm.edu, or deliver completed application to:

UVM Student Health Services, Attn: Parking Waiver Requests
425 Pearl Street, Burlington, VT 05401

Part 1a: To be completed by the student

Student Name (printed): __________________________ Date of Birth: _______________

UVM 95 #:____________ Local/School Address: ______________________________________

Cell phone #:_________________________ E-mail: ________________________________

I currently have a UVM parking permit: □ yes □ no

If yes: Commuter Gold, Commuter Brown, or Residential (Please circle one)

I am requesting: □ temporary on-campus parking permit □ temporary handicap parking permit

*I acknowledge that I have read & understand the guidelines for medically related parking waivers. I also understand that completing this form does not guarantee approval.

Student Signature: __________________________ Date: __________________________

________________________________________

SHS Parking Waiver Recommendation:

Part 1b: To be completed by SHS

☐ Health condition warrants a temporary on-campus parking permit.
☐ Health condition warrants a temporary handicap on-campus parking permit.
☐ Health condition can be accommodated with existing on-campus transportation services.

Expiration Date: __________________________

Signature of Certifying Official: __________________________ Date: __________

Printed Name: __________________________ Office/Position: __________________________

For SHS Office Use:
Received by: __________ Date: __________
Part II

Please fax (802) 656-8178, e-mail: CHWBMIF@uvm.edu, or deliver completed application to:

UVM Student Health Services, Attn: Parking Waiver Requests
425 Pearl Street, Burlington, VT 05401

Part 2a: To be completed by student

Student Name (printed): __________________________ Date of Birth: _________________

UVM 95 #: __________________________

Reason for this request (health condition): ____________________________________________________________

________________________________________________________________________________________________________

How will this parking modification support your need? __________________________________________________________

________________________________________________________________________________________________________

Expected duration of need: __________________________________________________________

Treating medical provider responsible for completing part 2:

Medical Provider's Name: __________________________________________________________

Practice Name: __________________________________________________________

Address: __________________________________________________________

Phone number: __________________________________________________________

For SHS Office Use:
Received by: __________
Date: __________

Form last modified: 3/27/17
Part III
To be completed by the medical provider treating the student

Please fax (802) 656-8178, e-mail: CHWBMIF@uvm.edu, or deliver completed application to:
UVM Student Health Services, Attn: Parking Waiver Requests
425 Pearl Street, Burlington, VT 05401

Medical Provider's Name: ________________________________________________________________
(Print full name and credentials)

License/Certification #:______________________________________________________________

Practice Name: ________________________________________________________________

Address: ________________________________________________________________

Phone: __________________ Fax: __________________

Patient's Name: __________________ DOB: ___________________

1. Patient’s diagnosis: ________________________________________________________________

*Please note whether the patient’s condition is □ chronic or □ acute

2. Description of medical condition and limitations: __________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

3. Expected duration of impairment: ______________________________________________________

4. Is the patient expected to use any medical equipment/devices? _________________________

If yes, please list here and indicate the length of time it will be needed: _______________________

____________________________________________________________________________________

____________________________________________________________________________________

5. Please indicate the maximum distance patient is able to ambulate without endangering their health:

Medical Provider’s Signature: __________________ Date: __________________

*The provider completing this form must be the treating healthcare provider and not related to the student.

For SHS Office Use:
Received by: __________ Date: __________