University of Vermont
Office of Accessibility Services

Employee Temporary ADA Parking Request Form

INSTRUCTIONS: Employees requesting temporary ADA parking accommodations must complete page one (1) of this form and have their treating licensed healthcare provider complete page two (2). Once complete, it should be submitted to the Office of Accessibility Services (OAS): access@uvm.edu.

Recommendations on this form do not automatically bind OAS to determine the employee eligible for specific accommodations. A provider's recommendations are taken into consideration as part of a full review that includes a multitude of factors, including the availability of designated parking spaces.

*****EMPLOYEE INFORMATION: TO BE COMPLETED BY THE EMPLOYEE*****

Employee Name: _____

Employee ID: _____

Department: _____

Job Title: _____

Work Email: _____

Work Phone: _____

PARKING REQUEST DETAILS:

Requested Start Date: _____

Estimated End Date: _____

Current Parking Permit Number (if applicable): _____

Reason for Request (Brief Description):

EMPLOYEE ACKNOWLEDGEMENT

I understand that this accommodation is temporary and subject to review. I certify that the information provided is accurate and acknowledge that any misrepresentation may result in the revocation of my temporary ADA parking permit.

Signature: _____ Date: _____

University of Vermont
Office of Accessibility Services

*****MEDICAL CERTIFICATION: TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER*****

Employee Name: _____ Date of Birth: _____

Provide the general nature of impairment based on the diagnosis or condition requiring a temporary parking accommodation. Do not disclose specific diagnosis if not required.

Additional supporting documentation from a healthcare provider, such as a medical note, emergency room discharge summary, or other relevant records, may be required to process this request.

Expected Duration of Need: _____

If needed, list medical equipment/devices expected to be used during this time: _____

Indicate the maximum distance the patient can ambulate without endangering their health: _____

Name and credentials of provider: _____

License number and state: _____

Associated organization: _____

Address: _____

Phone number: _____

Signature: _____ Date: _____

Submit this completed form to the Office of Accessibility Services (OAS) by email or fax:

Email: access@uvm.edu
Fax: 802-656-0739

Questions? Call the Office of Accessibility Services: 802-656-7753

University of Vermont
Office of Accessibility Services

*****FOR OAS OFFICE USE ONLY*****

Date Reviewed: _____

Reviewed By: _____

Eligibility Status: ☐ Eligible ☐ Not Eligible

Rationale If Not Eligible:

Temporary Permit Issued: ☐ Yes ☐ No

Permit Expiration Date: _____

Additional Notes:

Submit Completed Form To:

- Employee
- Transportation and Parking Services