The University of Vermont
Center for Health and Wellbeing Student Health Services
Temporary Medical Parking Permit Request Form

Instructions:

Please fully read the Request Process & Important Information before submitting your Medical Parking Permit Request. Completed forms should be submitted via secure file transfer **(https://filetransfer.uvm.edu/)** to CHWBMIF@uvm.edu or deliver completed application to Student Health Services, 425 Pearl Street, Burlington, VT 05401. **Please do not email the form.**

Request Process:

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

Important Information:

1. Receipt of an emergency temporary accessible parking permit from parking and transportation does not guarantee an accessible permit.
2. If granted a temporary on-campus permit, the student is responsible for associated fees.
3. Transportation for illness (personal, family, or friends) will not be accepted as a basis for granting a waiver.
4. Temporary parking for medical necessity will be evaluated within the parameters of Student Health Services.
5. Individuals with short term disabilities who anticipate their condition to continue for longer than 4 – 6 weeks are expected to apply through their State Department of Motor Vehicles for the appropriate disabled parking placard. Please refer to the Transportation & Parking Services web site www.uvm.edu/transportation for more information.

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Part I

To be completed by the student

Student Name (printed): _____Date of Birth: _____

UVM 95 #: _____ Local/School Address: _____

Cell phone #:_____ E-mail: _____

I currently live: □ on campus □ off campus

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

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

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

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

Student Signature:_____Date:_____

FOR OFFICE USE ONLY: To be completed by SHS

SHS Parking Waiver Recommendation:

□ Health condition warrants a temporary on-campus parking waiver.
□ Health condition warrants a temporary accessible on-campus parking waiver.
□ Health condition can be accommodated with existing on-campus and public transportation services.

Parking Permit Expiration Date: _____

Signature of Certifying Official: _____Date: _____

Printed Name: _____

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Part II

To be completed by student

Student Name (printed): _____ Date of Birth: _____

UVM 95 #: _____

Reason for this request (health condition):

_____

_____

_____

_____

_____

Treating medical provider responsible for completing Part III:

Medical Provider's Name: _____

Practice Name: _____

Address: _____

Phone number: _____

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Part III

To be completed by the medical provider treating the student

Student Name (printed): _____ **Date of Birth:** _____

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

License/Certification #:_____ **Practice Name:** _____

Address: _____

Phone: _____ **Fax:** _____

1. **Patient's diagnosis:** _____

_____

2. **Description of medical condition, limitations and expected duration of impairment:**

_____

_____

3. **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: _____

_____

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

Treating Medical Provider's Signature: _____ **Date:** _____