CENTER FOR ACADEMIC SUCCESS
STUDENT ACCESSIBILITY SERVICES

MEDICAL PROVIDER FORM – ADA Parking Accommodations
Information in this letter is confidential and should not be shared.

(This section to be filled out by the student)

Student Name: _____

UVM 95# _____ Class Year: _____

Provider Name, Credentials, & Specialty:

_____

Provider Phone: _____

Provider Address:_____

(This section to be filled out by the medical provider)

This form is utilized in consideration of a student's request for medical parking accommodations. These accommodations could include having a car on campus when they would otherwise not be eligible to obtain a parking pass.

The information you provide will be helpful to determine reasonable accommodations within the student's need and what is available on the campus. Information provided herein is closely considered, but is used only as a recommendation of the student's needs. Medical documentation will be kept on file at the Student Accessibility Services office, will be considered confidential health information and will be accessed only by personnel involved in evaluating and providing reasonable accommodation requests.

Please attach copies of current, comprehensive tests and/or laboratory work that support the student's diagnosis. Any documentation should be submitted on professional letterhead, signed, and the qualification of the examiner should be provided. The provider cannot be a relative of the student. For all requests, please include the following information:

1.Specific Diagnosis(es):_____

2.Date of Diagnosis(es): _____

Date of most recent student contact: _____

3.Statement as to the activities substantially limited by the condition and the level of severity:

_____
_____
_____
_____

4.Describe the student's functional limitation/behavioral manifestation necessitating access to a personal car (as opposed to other campus transportation resources):

_____
_____
_____

5.Describe how a personal car alleviates the symptoms:

_____
_____

6.Provide the student's appointment frequency (i.e.weekly, monthly, as needed, etc.): _____

7.Provide the student's required medical care duration (i.e. 1 month, 1 semester, indefinitely): _____

Provide anything else we need to know:

_____
_____
_____
_____

Medical Care Provider Signature:

_____

Medical Care Provider Printed Name:

_____

Today's Date: _____

Please return this form and accompanying documentation to:

Student Accessibility Services
access@uvm.edu
633 Main Street
A170 Living/Learning
Burlington, VT 05405
Phone: (802) 656-7753
Fax: (802) 656-0739

The University of Vermont provides reasonable accommodations to students with documented disabilities who qualify under the Americans with Disabilities Act of 1990 and Section 504 of Rehabilitation Act of 1973. These laws define a person with a disability as one who has a physical or mental impairment which substantially limits one or more major life activities. "Major life activities" include, but are not limited to functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, reproduction, and work.