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 I and II to Student Health Services.
2. Student is also responsible for having his/her 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 again, 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 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 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.
The University of Vermont
Center for Health and Wellbeing
Student Health Services
Temporary Medical Parking Permit Request Form

Part I
To be completed by 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

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 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:________________________

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 handicap on-campus parking waiver.
□ Health condition can be accommodated with existing on-campus transportation services.

Parking Permit Expiration Date: __________

Signature of Certifying Official: ___________________________ Date: __________
Printed Name: ___________________________ Office/Position: __________
The University of Vermont
Center for Health and Wellbeing Student Health Services
Temporary Medical Parking Permit Request Form

Part II
To be completed by 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

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: _________________________________________________________________
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

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

UVM 95 #: __________________________

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

5. their health: ________________________________________________________________

Treating Medical Provider's Signature: __________________________ Date: __________