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 #:____________________ 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: __________

Form last modified: 7/6/18
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 2: 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 3:

Medical Provider’s Name: _________________________________________________________

Practice Name: _________________________________________________________________

Address: _____________________________________________________________________

Phone number: __________________________________________________________________

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

Form last modified: 7/6/18
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: ________________

Form last modified: 7/6/18