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.

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 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 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.

Form last modified: 11/7/2023
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 accessible 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 accessible 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: ________________
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: ____________________________________________________________________
The University of Vermont
Center for Health and Wellbeing Student Health Services
Temporary Medical Parking Permit Request Form

Part III
To be completed by the medical provider treating the student

Please fax (802) 656-8178, e-mail: CHWBMIIF@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:

________________________________________________________________________

________________________________________________________________________

“In the event an affiliated individual develops a short-term disability through injury or illness, a temporary accessible placard may be issued by the University for no more than four weeks. This four-week period should be sufficient to assist with approved minor injuries or assess further needs and process a request for access through the state.” https://www.uvm.edu/transportation/accessible-parking

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: __________