DISABILITY-RELATED PARKING PERMIT REQUEST

Instructions:

Please fully read the Request Process & Important Information before submitting your Parking Permit Request from Student Accessibility Services.

Request Process:

1. Student is to complete and submit Parts 1a+ 2 to Student Accessibility Services.
2. Student is also responsible for having his/her treating provider complete and submit Part 3 to Student Accessibility Services.
3. The final SAS Parking Accommodation (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 Transportation & Parking Services will be notified via UVM e-mail.

Important Information:

If granted an on-campus permit, the student is responsible for associated fees.

Please fax (802) 656-0739, e-mail: ACCESS@uvm.edu, or deliver completed application to:

UVM Student Accessibility Services
633 Main Street, A170 Living Learning, Burlington, VT 05405
Part 1

Part 1a: To be completed by the student

Student Name (printed): ___________________________ Date of Birth: ___________________

UVM 95 #:_________________ Local/School Address:________________________________

Cell phone #: _________________________ E-mail: _______________________________________

I am requesting:  ____ First Year student: on-campus parking permit

  ____ Returning Student – on campus parking permit

*1 acknowledge that I understand that completing this form does not guarantee approval.

Student Signature: ___________________________ Date: __________________

*SAS Parking Accommodation:

Part 1b: To be completed by SAS

□ Health condition warrants an on-campus parking permit – First year student.
□ Health condition warrants an on-campus parking permit – Returning student
□ Health condition can be accommodated with existing on-campus transportation services.
□ Health condition does not warrant an on-campus parking permit.

Signature of Certifying Official: ___________________________ Date: _____________

Printed Name:__________________________________________
Please fax (802) 656-0739, e-mail: ACCESS@uvm.edu, or deliver completed application to:

UVM Student Accessibility Services
633 Main Street, A170 Living Learning, Burlington, VT 05405

Part 2: To be completed by student

Student Name (printed): ___________________________ Date of Birth: ____________________

UVM 95 #:____________________

Reason for this request (health condition):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

How will on-campus parking support your need as related to an ADA disability?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Treating medical provider responsible for completing part 3:

Medical Provider's Name: ________________________________

Practice Name: ________________________________

Address: ________________________________

Phone number: ________________________________
Part III
To be completed by the medical provider treating the student

Please fax (802) 656-0739, e-mail: ACCESS@uvm.edu, or deliver completed application to:

UVM Student Accessibility Services
633 Main Street, A170 Living Learning, Burlington, VT 05405

Medical Provider’s Name: ____________________________________________________________

(Print full name and credentials)

License/Certification #: ____________________________________________________________

Practice Name: ___________________________________________________________________

Address: __________________________________________________________________________

Phone: __________________________ Fax: __________________________

Patient’s Name: ____________________ DOB: __________________

Patient’s Diagnosis: ________________________________________________________________

Description of medical condition and functional limitations as related to the Americans with Disability Act which would require this patient to have a car on campus. ________________________________

____________________________________________________________________________________

___________________________________________________________________________________

Any additional information that would be relevant for Student Accessibility Services to consider in granting this accommodation: ________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Medical Provider’s Signature: __________________________________________________________

Date: ____________________________