

Medical Parking Permit Application

Student

Name of Student (Last, First, Middle Initial)

Messiah ID #

Resident Building, (or list Commuter)

Current Parking Lot (if applicable)

☐

As a member of the Messiah University Community, I understand the serious nature of requesting a medical accommodation for parking and certify that I have a medical necessity that severely affect mobility or involves acute sensitivity to light or cold. I recognize that disability parking is only to be used by those who qualify as disabled or are requiring a medical accommodation by a certified health care provider. I understand that those who abuse this privilege will forfeit their parking spot and accept disciplinary actions as stated in the Messiah University Student Handbook.

Date

Student Signature

Physician (to be completed by **MD** or **DO** ONLY)

Name of Physician

Business Address

Professional Classification

Professional License #

(Area code) Telephone Number

Student Medical Accommodation

Medical parking duration required (weeks)

(choose one)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 (maximum 8 weeks)

☐ Student cannot continuously walk more than _____ feet

☐ This student qualifies and has applied for a state issued handicap placard and should park in a handicap space.

Date

Signature of MD or DO **only**