Lebanon Valley College

Application for Temporary Parking Permit for Medical Reason

Student

Name of Student (Last, First, Middle Initial)	LVC ID #
Resident Building, (or list Commuter)	

☐ As a member of the Lebanon Valley College community, I understand the serious nature of requesting a medical accommodation for parking and certify that I have a medical necessity that severely affects 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.

_____ _____

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**