Parking Exception Form

This application is to request parking on campus due to a disability or medical condition. Requests for an exception will be reviewed on a case-by-case basis. Frequency, duration, and location of treatment facility will be considered as part of the review process. Your request must be accompanied by the attached certification form which must be completed by your treating professional. Please return completed request and certification form to the Office of Accessibility Resources.

Name: _____ Drew ID: _____

Permanent Address: _____
and Street City, State Zip Code

On-Campus Housing: _____
(Residence Hall Name and Room #)

Academic Year: _____ Phone Number: _____

Drew Email: _____

1. Have you had this accommodation at Drew University in the past? _____

2. What is the treatment type (ie., counseling, physical therapy, etc.)? _____

3. Please describe how this parking accommodation will reduce the impact of your disability and/or health condition?

_____

_____

4. Please add any other information you feel is important for us to consider in reviewing your request.

_____

_____

Student's Signature: _____ Date: _____

Treating Professional Form

Student, _____ has applied for parking at Drew University. He/She is not entitled to on-campus parking and is requesting an exception to the parking regulations. Exceptions to this parking requirement may be considered for students with a disability or medical condition for having a car on campus. Requests for an exception will be reviewed on a case-by-case basis and frequency, duration, and location of treatment will be considered during the approval process. Please complete the form below so that the student's request can be reviewed.

Student's diagnosis/condition: _____

Date of most recent office visit: _____

Location of office/treatment facility: _____
and Street City, State Zip Code

Type of treatment: _____

Frequency of treatment that requires the student to commute from Drew University to the provider's office during the academic year: _____

Duration of treatment (please include start date and anticipated end date): _____

Reasons for ready access to own transportation (cannot include "just in case" circumstances):

_____

_____

Provider's name: _____

Provider's office address (if different from above): _____
and Street City, State Zip Code

Provider's office phone: _____

Provider's fax number: _____

We will contact you if further information is needed. Thank you.

Provider's Signature: _____ Date: _____

Provider's ID/License: _____