APPEAL OF THE UM FRESHMAN/SOPHOMORE PARKING POLICY

Complete all the information listed below and sign where indicated, if applicable. Return completed form to Parking and Transportation Services, 523 South Division Street, Ann Arbor, MI 48104-2912.

STUDENT INFORMATION

Applicant Name _____

UMID # _____ Date of Request _____

Permanent Address _____

City/State/Zip _____

Local Address _____

Permanent Phone # _____ Local Phone # _____

Is your appeal based on your personal health issues? **Yes** **No**

If yes, complete authorization below and forward the Physician's Statement form to your medical physician for completion. The statement must be completed by an M.D. Return both sections to Parking and Transportation Services.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of the medical information requested to the University of Michigan, Parking and Transportation Services department, in support of my request for parking privileges.

Signature _____ Date _____

What specific problem(s) or circumstances are you experiencing that would necessitate having your vehicle on campus?

_____

_____

_____

_____

What would be the benefit of having your vehicle on campus?

_____

_____

_____

How often would you use your vehicle? _____

What is the period of time you require your vehicle on campus?

Beginning Date _____ End Date _____

PHYSICIAN'S STATEMENT

The applicant has stated that due to their specific medical condition, they must have their vehicle on campus. To assist us in reaching a decision on their request, we require the following information about the applicant's condition. Please complete the information below.

PHYSICIAN INFORMATION

Name _____ Phone _____

Specialty _____ Medical License # _____

Address _____

City/State/Zip _____

REPORT OF APPLICANT'S MEDICAL CONDITION

What is the diagnosis of the applicant's medical condition? _____

_____

Does the applicant require regular treatment? **Yes** **No**

If yes, how often? _____

Could the treatment be performed locally? **Yes** **No**

Is the condition temporary? **Yes** **No**

If temporary, what is the duration of the condition? **From** _____ **through** _____
(Please be as specific as possible)

Would the applicant qualify for a state disability placard? **Yes** **No**

Will walking negatively affect the condition? **Yes** **No**

Do extreme weather conditions negatively affect the patient's condition? **Yes** **No**

If yes, please describe what kind of conditions. _____

_____

Please share any additional information you have which may assist us in this determination. _____

_____

_____

_____

Signature _____ Date _____