YORK COLLEGE OF PENNSYLVANIA

DEPARTMENT OF CAMPUS SAFETY

441 COUNTRY CLUB ROAD PHONE (717) 815-1403

YORK, PA 17403-3651 FAX (717) 849-1654

EMAIL campussafety@ycp.edu

REQUEST FOR TEMPORARY HANDICAP PARKING

Complete all the information listed below and sign where indicated. Return completed form to the Campus Safety office for processing. Temporary handicap permits are only valid for one semester. Extensions may be permitted by resubmitting a new request.

STUDENT INFORMATION

Applicant Name: _____

YCP 9-digit ID Number: _____ Date of Request: _____

Local Address: _____

Permanent Phone #: _____ Cell Phone #: _____

What specific problem(s) or circumstances are you experiencing that would necessitate a temporary handicap parking permit.

_____

_____

_____

_____

_____

_____

_____

Complete authorization below for a temporary handicap permit 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 the Campus Safety office.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of the medical information requested to the Department of Campus Safety, York College of Pennsylvania, in support of my request for a temporary handicap parking permit to be used on campus.

Signature _____ Date _____

PHYSICIAN'S STATEMENT

The applicant has stated that due to their specific medical condition, they must utilize handicap parking on the Campus of York College of Pennsylvania. 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? _____

Is the condition temporary? YES NO

If temporary, what is the duration of the condition? From _____ through _____

(Please be as specific as possible as these dates will be used to validate the handicap permit if approved)

Would the applicant qualify for a state disability placard? YES NO

Will walking/taking a bus or shuttle negatively affect the condition? YES NO

Does 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 _____