UMass Boston Office of Civil Rights and Title IX
Temporary Disability Parking Permit Application

NAME: _______________________________________________________________________

EMPLOYEE ID: ________________________ PHONE: _______________________________

EMAIL ADDRESS: _____________________________________________________________

DATES PARKING NEEDED ______________ TO _____________ (MAXIMUM 8 WEEKS)

I am aware that any request for an extension of this temporary parking may be denied and so it has been recommended to me to consider obtaining a state-issued Disability Parking Placard.

I have attached my health care provider’s current certification for this temporary disability parking permit. I am aware that the medical information provided by my health care provider in support of my application must demonstrate a direct link between the underlying condition and the requested accommodation and specify the expected duration of the temporary disability. I understand that some conditions may not qualify for a temporary disability parking permit (including, hypoglycemia, allergies, migraine headaches, etc.)

I agree to comply with all policies and procedures related to the UMass Boston parking regulations, including purchasing a valid UMass Boston parking pass.

I am aware that all of the UMass Boston shuttles are handicap accessible, and are equipped with a wheel-chair lift. The larger shuttles are also low floor and have the ability to “kneel” to allow access. If negotiating steps is difficult, the lift can be activated to assist boarding and un-boarding of the shuttle.

SIGNATURE_____________________________________________ DATE_______________

FOR THE OFFICE OF CIVIL RIGHTS AND TITLE IX ONLY:

____APPROVED ____ DENIED

____ REQUEST FOR MORE INFORMATION

_______________________________________________CRTIX SIGNATURE
Temporary Disability Parking Permit Application:

Certification of Applicant’s Disability

To be completed by personal health care provider. Please print. Check all that apply:

The above-named individual’s disability: ______________________________________________

Nature of Medical Condition: ______________________________________________________

Duration of Need for Temporary Parking: ____________________________________________

Prescribed Ambulatory Aid(s): _____________________________________________________
(Examples: cane, brace, crutch, wheelchair, prosthetic device)

Walking Distance Ability: _________________________________________________________

By signing this document, I authorize the Office of Civil Rights and Title IX to contact me to obtain further patient information if needed. I certify that the above information is accurate to the best of my knowledge.

Health Care Provider’s Signature: _________________________________ Date:______________

Printed Name: Last, First, M.I.____________________________________________________

Office Address__________________________________________________________________

Office Phone ___________________________________________________________________

Professional License Number Including State__________________________________________