



To Whom It May Concern:

Below is the Application for Accessibility Parking. This form must be filled out by both the requestor and a doctor. Please make sure your application includes the following:

1. A clear diagnosis of the disability written by a medical professional who is qualified to diagnose and treat the disclosed disability.
2. Documentation of the disability must be current. (The age of the required documentation also may be dependent upon the nature of the disability and the specific requested accommodation.)
3. A statement of the functional impact and limitations of the disability in regards to mobility. If the permit is requested for medical appointments the frequency, location, and duration of the appointments must be cited by the doctor.
4. Please note parking in an accessible parking space is only permitted with a state issued placard.

Please make sure that all of the required information above is included in your doctor's letter. If any information is unclear or missing, the permit timeline for a decision can increase. So, we ask that all information be included in the application to make the process as quick as possible.

Please email disabsrv@bc.edu or call 617-552-3470 if you have any questions.

Sincerely,

Rory Stein
Assistant Dean, Student Disability Services

Application for Accessibility Parking

Disability Services Office

Due to limited availability of parking on the Boston College campus, accessibility permits are only issued to individuals with appropriate documentation and demonstrated need. All permits require annual verification from a physician. Permit prices will be adjusted if granted accordingly.

Part 1 – To be filled out by the Requestor		
Please check one: <input type="checkbox"/> Student <input type="checkbox"/> Employee (Faculty or Staff) <input type="checkbox"/> Other: _____		What type of permit are you looking to obtain? Description of Permit Types <input type="checkbox"/> Temporary Employee Parking <input type="checkbox"/> Resident Student Overnight Parking <input type="checkbox"/> Other, please specify: _____
First Name:	Last Name:	Eagle ID:
Campus Phone (if applicable):	Mobile Phone:	Email Address:
Campus Address:	Other locations you frequent on campus:	
Detailed rationale for accessibility permit request (Please attach another sheet of paper if needed):		
Signature		Date

Part 2 – To be filled out by Medical Provider

A medical report or letter, responding to items listed below can be attached to this application for review in lieu of using this form. Specific information regarding the nature of the request MUST be provided in order to properly evaluate this documentation.

Physician's Name:

Name of Practice:

Address:

Telephone:

Fax:

Description of Patient's condition (Please attach another sheet of paper if needed):

Duration of Impairment:

☐ Permanent – Should obtain state HP placard☐ Temporary – Expected duration: _____

Does this Person Require a Wheelchair/Scooter?:

☐ Yes☐ No

Please indicate the maximum distance that can be negotiated without endangering patient's health:

(Circle one) <200 Ft. 200-300 Ft. 400 Ft. 2-3 Blocks 3-4 Blocks >4 Blocks

Can the individual park in an outer lot and ride a transit system (that is fully accessible) with this condition?

☐ Yes☐ No If no, explain: _____Reason for doctor's visits: ☐ Medical☐ Physical Therapy☐ Therapy (w/ psychologist, psychiatrist, etc.)

*If needed for doctor's appointments, please state:

Frequency of doctor's visits:

Location of Doctor's Office:

Physician's Signature: _____

Date: _____