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 that your application includes the following:

1. A clear diagnosis of the disability/condition written by a medical professional.

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. *A list of recommended parking accommodations with an explanation of its relation to the disability or condition.*

5. 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. A DECISION CANNOT BE MADE WITHOUT THE INFORMATION ABOVE. THE LENGTH OF TIME NEEDED TO MAKE A DECISION WILL INCREASE IF INFORMATION IS UNCLEAR OR INCOMPLETE.

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.

If you are an employee the information can be emailed to Office for Institutional Diversity judy.ferres@bc.edu or call 617-552-2947. All requests made by faculty and staff are reviewed by the Office for Institutional Diversity.

If you are a student please contact Disability Office at disabsrv@bc.edu or call 617-552-3470. All requests made by students are reviewed by the Disability Office.

Sincerely,

John Savino
Manager, Transportation and Parking
Application for Accessibility Parking
Office of Auxiliary Services

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.

To be Completed by Requestor:

Please Check One:  ( ) Student    ( ) Employee    ( ) Other

Last Name: ___________________ First Name: ___________________ Today’s Date: ___________________

Email Address: ___________________ Telephone: ___________________

Campus Address: ___________________ Local Address (City, State) ___________________

Eagle ID #: ___________________ Class Year (if appropriate): ___________________

Detailed rationale for accessibility permit request: (Please attach details on another sheet of paper if needed)

What type of permit are you looking to obtain?

( ) Temporary Employee Parking

( ) Resident Student Overnight Parking

http://www.bc.edu/content/bc/offices/transportation/parking/employeeparking.html

Signature of Requestor (Required for release of information): ___________________ __________

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 problem MUST be provided in order to properly evaluate this documentation. EVERY QUESTION BELOW MUST BE ANSWERED.

Physicians Name (Print): ___________________ Name of Practice: ___________________

Address (City, State): ____________________________________________________________

Telephone: ___________________ Fax: ___________________

Please use terminology easily understood by non-medical staff.

Use additional paper, if necessary.

1. Please describe patient’s condition: ________________________________________________

2. Duration of Impairment:

( ) Permanent – Should obtain state HP placard

( ) Temporary – Expected duration of impairment ___________________

3. If needed for doctor’s appointments please state:

Frequency of doctor’s visits ___________________

Location of doctor’s visits: Street & #: ___________________ City/Town: __________ State: __________

4. Reason for Doctor’s Visits:

( ) Medical

( ) Physical Therapy

( ) Therapy w/psychologist/psychiatrist, etc…

( ) Other

5. Does this person require a wheelchair/Scooter?  ( ) No    ( ) Yes

6. 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

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

( ) YES  ( ) NO If no, explain

______________________________________________________ ______________________

Signature of Physician: ___________________ Date: ___________________

Employee Return this form to:
Office for Institutional Diversity, email: judy.ferrers@bc.edu, fax: 671-552-4674 or call 617-552-2947

Students Return this form to:
Disability Services, email: disabsrv@bc.edu, fax: 617-552-3473 or call 617-552-3470