



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:

- A clear diagnosis of the disability/condition written by a medical professional
- 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.)
- Duration of recovery if a temporary injury
- 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.
- 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.

All requests made by faculty and staff are reviewed by Transportation & Parking and by William Murphy, Associate Vice President for Human Resources. All requests made by students are reviewed by the Assistant Dean for Students with Disabilities.

Sincerely,

Rory Stein  
Assistant Dean for Students with Disabilities

**Application for Accessibility Parking**

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 Parking ( ) Overnight Parking ( ) Resident Student Parking ( )  
Commuter Parking

For what parking area are you seeking access? ( )A ( )M ( )R ( )G Description  
of permit types:

<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: \_\_\_\_\_

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*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 wheel chair/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: \_\_\_\_\_

**Return this form to:**

**Disability Services Office**

Email: [disabsrv@bc.edu](mailto:disabsrv@bc.edu)

Fax: 617-552-3473