Utah State University
Medical Permit Eligibility Form

Patient ______________________________

Patient Address ______________________________

City ________________ State ______ Zip ________

Doctor ______________________________

Speciality ______________________________

Office Phone ______________ Fax ____________

Contact Person (if other than doctor) ____________

The above individual is seeking a Utah State University parking permit which would allow him/her to park in close proximity to his/her destination. These permits are only approved under extreme circumstances and serious scrutiny should be given to those patients requesting such privileges. Please read and sign the statement below.

I certify that the above patient is currently under my care and he/she has a need for close proximity parking on the Utah State University campus.

How long do you anticipate the patient having this condition? (NOTE: If the condition is anticipated to last longer than three months, he/she should complete the process for obtaining a disabled access permit through the state.)

__________ Days __________ Weeks

Signed ______________________________ Date ______________________________

Please return form to the following address:
USU Parking
7100 Old Main Hill
Logan, Utah 84322-7100

Or Fax
(435) 797-3476