Health Care Professional Statement (Medical Non-Mobility Hardship)

Applicant Name (Print): _____

Authorization for Release of Information
I give permission for the treating health care professional to provide information relative to my condition as it relates to my need to travel to appointments or accomplish other medical-related activities. Students may contact Campus Health Services at 919-966-2281 for assistance with this form.

I have read this application in its entirety and to the best of my knowledge, all information provided in this application is correct and I have acted in accordance with the University Honor Code in providing such information. I understand and acknowledge that I am responsible for costs associated with a parking permit or transportation options assigned through the Medical Non-Mobility Hardship Parking Process.

Applicant's Signature: _____ Date: _____

Health Care Professional Section

This form should be completed by the treating Health Care professional (who is not related to the applicant) to provide information to support the applicant's need to travel for appointments or accomplish other medical-related activities. The health care professional must have the expertise to provide a diagnosis and the ability to speak about travel requirements associated with the applicant's condition as it relates to this transportation accommodation request.

UNC campus has limited proximate parking, similar to an urban environment. Depending upon the applicant's primary campus location(s), accommodations may include a campus parking permit or Zipcar.

Please ensure that this form includes sufficient detail to allow the Transportation and Parking Accommodations Committee to provide a reasonable transportation accommodation.

1. Provide a descriptive diagnosis and speak to the current and near-term travel requirements as it relates to this transportation request.

2. Indicate if the need for the Medical Non-Mobility Hardship request is:

   ☐ Permanent

   ☐ Temporary (Dates: From _____ To _____

3. How frequently is the accommodation needed?
   a. How many times daily? _____
   b. How many times weekly? _____
4. Additional information for travel requirements

5. Are there specific activities, limitations, or aggravating conditions not listed above that the Committee should consider in providing the transportation accommodation?

Health Care Professional's Name (Printed): _____Telephone Number: _____

Address: _____

City State Zip: _____

Health Care Professional's Signature _____ Date _____