

APPLICATION FOR MEDICAL PARKING PERMIT

Please complete this form and provide a note from your medical provider.

Then return the information to: Granoff Student Health Services, 501 Crescent Street, New Haven, CT

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Name _____ Date: _____

Address: _____ For: Fall _____ Spring _____ Semester

_____ Other _____ Semester

Phone: _____ Student Parking Permit Number _____

Do you have a Department of Motor Vehicles Permit? _ NO _____ _ Yes _____

Type of Vehicle _____ Marker Number _____

SCSUParking permit number _____

CLASS SCHEDULE:

DAYS: _____ BUILDING _____

MORNING: _____ AFTERNOON: _____ EVENING _____

After signature from Health Services please take to Campus Police for actual permit.

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FOR HEALTH SERVICE USE ONLY:

Issuing Authority _____ Date: _____

Recommended permit period from _____ TO _____