EMPLOYEE TEMPORARY
ACCESSIBLE PARKING PERMIT

Date of application: _____

Last Name: _____ First Name: _____

ID #: _____ Adelphi Decal #: _____ Vehicle License: _____

THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER: (MD, DO,NP, PA)

Medical Diagnosis: _____
_____

Type of medical issue causing need for temporary access: (for example breathing problems, orthopedic injury, etc..) _____
_____

Length of time requesting accessible parking permit for: (maximum is 3 months)
_____

Providers Name: (Printed) _____

Office Phone Number: _____

Providers Signature: _____

OFFICE STAMP: _____