



DISABILITY SUPPORT  
SERVICES  
*Student Affairs and Enrollment Services*

**SETON HALL UNIVERSITY**

**Student Application for Medical Exception Parking 2008 - 2009**

*Parking at the university is typically reserved for seniors, graduate students, staff, faculty, and commuting students. By completing the application below, you are requesting parking on campus because of a medical necessity. Your request must be accompanied by the attached certification form from your health care provider. You must also have verified that no other means of transportation can be arranged to meet your exceptional medical needs.*

Name: \_\_\_\_\_ SHU ID # \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street & Number City

\_\_\_\_\_ State Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\*\*\*\*\*

Campus Housing: \_\_\_\_\_  
Residence Hall Name Room Number

Off Campus Private Housing: \_\_\_\_\_  
Street, Number, Apt #, City, State, Zip

Signature \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

**DSS Office Use Only:**

Date Received: \_\_\_\_\_

Date Processed: \_\_\_\_\_

\_\_\_ Approved: End-date: \_\_\_\_\_

\_\_\_ Denied

Date Sent to Parking Office: \_\_\_\_\_

DSS Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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**Physician Certification**

*Your patient, \_\_\_\_\_, has applied for parking at SHU. He/she is not entitled to parking and is requesting an exception to our parking regulations. The student is making this request because he/she is under your care on a regular basis and cannot find alternative transportation to your office. Please complete the information below so that the student's request can be granted.*

Diagnosis: \_\_\_\_\_

Date of most recent office visit: \_\_\_\_\_

***Frequency and duration*** of treatment that requires student to commute from the Seton Hall South Orange campus to the provider's office during the college academic year:

\_\_\_\_\_

Location of treatment: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Office Address: \_\_\_\_\_

\_\_\_\_\_

Provider Office Phone: \_\_\_\_\_

Provider Fax Number: \_\_\_\_\_

\*\*\*\*\*

**CERTIFICATION of TEMPORARY DISABLING CONDITION**

I certify that my patient, \_\_\_\_\_, will need a car on campus in order to continue recurring treatment that is critical to his/her health.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider ID Number: \_\_\_\_\_

*Please return form to your patient, or mail or fax to the address below.*

**Disability Support Services; Seton Hall University; Duffy Hall, Room 67; 400 South Orange Avenue;  
South Orange, NJ 07079**

**Phone: 973-313-6364 -- Fax: 973-761-9185**