Department of Public Safety, Parking Services Division
123 Michael Schwartz Center
Kent, OH 44242
Phone (330) 672-4432

Temporary Disability Permit Application

RETURN THIS FORM BY FAX ONLY TO (330) 672-4034. **DO NOT GIVE TO PATIENT TO RETURN.**

NAME:____

BANNER ID_______________________________ PHONE ______________________________

LOCAL ADDRESS:____

By signing and completing this form, I understand that I am requesting disability parking privileges and that my personal physician will review my request. I agree to comply with all policies and procedures related to the Kent State University parking regulations. I certify that the above information is valid and truthful to the best of my knowledge.

SIGNATURE____ DATE_____________________

This form is good for a maximum of ONE MONTH only. Additional time requires a State Disability Placard.

The following areas must be entirely filled out by a licensed Medical Provider:

DATES PARKING NEEDED ____________ TO _______________ (MAXIMUM 1 MONTH)

TYPE OF PARKING REQUESTED:

☐ DISABILITY **OR** ☐ LOT PARKING
(Choice of 2 lots close to dorm/classes)

I certify that the above listed individual meets the criteria for the type of disability parking selected.

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Signature of physician Print name of physician Medical license number

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Physician's phone number Physician's fax number

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