Special Permit Request

To help us evaluate your specific problem and establish priorities for the limited number of permits available, please answer the following questions:

1. Type of injury, surgery, or disability_____
   _____
2. Date of above_____
3. Date when first seen by a physician for this condition_____
4. Physician Name_____
5. Address_____
6. Phone #_____
7. Limitations of my activity recommended by my physician_____
   _____
8. Length of time physician recommends limitations_____
9. Date of follow-up appointments_____
10. Current medication/treatment_____
    _____
    _____

_____ _____

Signature of student Date

_____ _____

Printed name of student Student I.D. (T #)

_____ _____

Signature of Medical Provider Date