ST. JOHN FISHER COLLEGE

Medical Parking Appeal
Provider Verification Form

Student Information	
Student Name	Date of Birth
SJFC ID Number @	SNN, Last 4 Digits

To be completed by HEALTH CARE PROVIDER

Diagnostic Information	
Diagnosis	
Date of Initial Diagnosis	Date of Last Contact with Student
Is the student currently under your care? □ Yes □ No	If yes, how often do you see the student?

Treatment Information	
Does the student require ongoing treatment in your office or another location? □ Yes □ No	
If yes, please describe the student's medical treatment plan including the provider name if different.	Location of Off Campus Treatment
	Frequency of Off Campus Treatment
Notes or Other Recommendations	

Provider Information	
Provider Name *(Print or Stamp)*	Provider Signature
Street Address	City/State/Zip Code
Date Form Completed	Phone Number

Please Return Completed Form To: Health & Wellness Center OR Fax: 585-385-8299
St. John Fisher College
3690 East Avenue
Rochester, NY 14618

For questions regarding this form, please call 585-385-8280