Duke University Student Temporary Medical Need Van Service Transportation Request

Information and Instructions

Students may request temporary van service transportation for a qualified medical condition. The form must be completed by the healthcare provider treating the problem. The provider (MD, DO, PA, NP, PT, ATC) cannot be someone with whom you have a significant emotional relationship (e.g. parent, sibling, or other relative). Recommendations and/or statements included in the medical documentation should not be interpreted as automatic approvals for special parking. Previously approved van service transportation from Duke or other institutions or agencies does not guarantee approval of this request.

Van Services rides are not guaranteed; they are based upon availability of resources.

Please email the form to: tranpark@duke.edu
Duke University Student Temporary Medical Need Van Service Transportation Request

FOR STUDENT TO COMPLETE:

Student Name: _________________________________  Date: ________________
Duke Unique ID: _______________________________  DOB: ______________________
Address: _____________________________________________________________________________  (Please provide local or campus address)
Phone: ___________________________ Duke E-mail: ___________________________

________________________________________                 ________________
Student Signature                                                                 Date

FOR LICENSED HEALTHCARE PROVIDER TO COMPLETE:

Date of Injury/Surgery: ______________________

Is student able to ride the bus?            ☐ No            ☐ Yes

If “No”:  Duke University Parking & Transportation Services offers comprehensive transit options that includes transportation from parking lots, frequent stops, multiple campus routes, and shuttle services. Please describe in detail why student cannot ride the bus:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Will the student require a mobility device? If so, what kind?: ______________________________

How long will dedicated transportation be required?  List a specific amount of time__________________
If more than 4 weeks are required, a reassessment must be completed and a new request submitted.

____________________________________    ______________________________             ___________
Signature of healthcare provider      Printed name of healthcare provider          Date

.Provider Address: __________________________________________________________
Telephone & Fax:  __________________________________________________________

Official Provider stamp:

Please email to: tranpark@duke.edu