

Lewis-Gale Medical Center
Parking Application for Students

Student's Name: _____

Date: _____

Affiliation: _____

Instructor / Facilitator's Name: _____

Make of Vehicle #1 _____

Make of Vehicle #2 _____

Make of Vehicle #3 _____

Vehicle Tag Number #1 _____

Vehicle Tag Number #2 _____

Vehicle Tag Number #3 _____

I, _____, agree to park only in parking areas designated for Lewis-Gale Medical Center employees, associates and students.