HEALTHCARE REALTY

Parking Pass

Check one: ☐ **Doctor**   ☐ **Employee**

Note: Employees of Fountain Valley Regional Hospital must contact hospital administration for a parking pass.

Tenant name: _____

Building address: _____   Suite #: _____

Phone: _____   Fax: _____   Tenant contact email: _____

Request details

1	**RECIPIENT**

Name: _____   Phone: _____

Email: _____

2	**PASS TYPE:** ☐ New parking pass ☐ Temporary parking pass ☐ Replacement hanging parking pass

3	LICENSE PLATE NUMBER:	MAKE:	MODEL:	COLOR:	YEAR:
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Note: No one other than the recipient should use the recipient's parking pass. Vehicles without appropriate parking pass are subject to be towed immediately at vehicle owner's expense.

AUTHORIZED BY (if applicable):

Signature _____ **Date** _____
(Electronic signature represented by blue type)

Name (print) _____ **Title** _____

PARKING PASS RECEIVED BY:

Signature _____ **Date** _____
(Electronic signature represented by blue type)

Name (print) _____ **Title** _____

··· OFFICE USE ONLY ·····················

Pass number: _____   By: _____   Date: ____ / ____ / _____
Initials

Called requester to pick up on: ____ / ____ / _____   and/or emailed tenant on: ____ / ____ / _____   Date logged: ____ / ____ / _____

Revised Sept. 2015

✉ **Click to email form**