Please check which location(s) the Physician will need parking access. If there are multiple locations, please state below what the Physician's main location will be and what the subsidiary location(s) are:

☐ AGH ☐WPH ☐Jefferson ☐Forbes ☐Allegheny Valley

☐Canonsburg ☐4AC ☐Federal North ☐Other

- Main Facility: _____
- Subsidiary Facility: _____

Lease Payment Options:

☐Payroll Deduction

☐Department

Cost Center Associated with Department: _____

☐Credit Card

Contact Parking Department associated with facility to arrange automatic payments.

Lease Parking Registration

_____ _____ _____

Last Name First Name Middle Initial

_____ _____ _____

Department Title Phone/Pager

_____

Home Address

_____ _____ _____ _____ _____

Make Model Color Year License Plate #

For Office Use Only:

Proxy #: _____

I agree to pay the amount designated and I further understand that the hospital may modify the amount of lease parking in the event my monthly parking lease should change. This agreement is legally binding. I understand that I may terminate this agreement at any time.

Signature: _____ Date: _____

*****Email completed form to Chelsea.Fine2@ahn.org & Joey.Villafania@ahn.org *****