MONTEFIORE NYACK HOSPITAL

Employee Parking Access Application

Last Name: _____ First Name: _____

Department: _____ Job Title: _____ Employee ID#: _____

A. EMPLOYEE INFORMATION:

Mobile Phone: _____ Personal Email: _____

Shift Hours: _____ AM / PM to _____ AM / PM

Employment Status (check one): ☐ FT ☐ PT ☐ Per Diem

Shift: ☐ Day ☐ Evening ☐ Night

ID Badge Information: ☐ Employee ☐ Volunteer

Vehicle Information: (Failure to provide information may result in loss of parking privileges)

Vehicle Make: _____ Vehicle Model: _____

Vehicle Color: _____ Vehicle Plate #: _____

I hereby authorize Montefiore Nyack Hospital to deduct monthly from my paycheck the cost for parking based on my employment status. (Full Time Days = $70, Part Time/Per Diem Days = $30 ***or*** Evening Shift = $20)

Signature: _____ Date: _____

B. PARKING ACCESS CANCELLATION:

☐ I authorize the cancellation of my parking access.

Signature: _____ Date: _____

PARKING INFORMATION (To be completed by Security):

Prox Card #: _____ Shift: [ ] Day [ ] Evening [ ] Night Location: _____ Vehicle Tag#: _____

Parking clearance granted by: _____

Parking Access Application 12/2022

Montefiore Nyack Hospital
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Nyack, NY 10960
845-348-2000
montefiorenyack.org

Montefiore | Nyack