#_____/_____
(For office use only)

Parking and Transportation Services
UC Davis Medical Center
4800 2nd Avenue, Suite 1100
Sacramento, CA 95817

Phone: 916-734-2687 **FAX: 916-734-0600**

REQUEST FOR PARKING CITATION REVIEW

☐ Patient ☐ Visitor ☐ Employee ☐ Student ☐ Vender/Contractor

Name: _____ Phone No.: _____

Address:_____City: _____ State:_____ Zip: _____

Citation No(s): _____ Date:_____ Vehicle License No.:_____

Please state why you are contesting the above citation(s). Provide all pertinent information and be as detailed as possible; attach any applicable evidence. Use additional sheets of paper if necessary. All citations must be paid or appealed within 21 days of issuance.

ATTACH A COPY OF YOUR CITATION(S) TO THIS FORM.

I certify that the above is a true and accurate statement of my appeal.

Signature: _____Date: _____