Texas Medical Center

Parking Dismissal & Refund Request

☐ Refund Request ☐ Citation Dismissal Request ☐ Voucher Dismissal Request

Please Print

Institution	Customer Card or Proximity Card Number

Last Name	First Name

Address

Phone Number	Parking Facility

Citation or Voucher Number	Vehicle License Plate Number

$ _____

Refund/Dismissal Amount Requested

_____

Customer Signature Date

Reason for Request:

_____

_____

_____

DO NOT COMPLETE THE INFORMATION BELOW. FOR TMC USE ONLY.

☐ Approved ☐ Denied ☐ Check box if refund is taxable

_____ _____

TMC Representative Signature Date TMC Management Signature Date

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This is a request only. All dismissal requests and refunds are subject to Texas Medical Center approval.

Please fax or Mail this form to:

Texas Medical Center
John P. McGovern Campus
Customer Relations Department
2450 Holcombe Blvd, Suite 1
Houston, Texas 77021-2040
Fax: (713) 791-6143

For questions or comments, please call Customer Relations @ (713) 791-6161, Monday through Friday 7:00 a.m.-11:00 p.m.

Revised – 12/23/05