City of Somerville

DEPARTMENT OF TRAFFIC & PARKING
traffic@somervillema.gov
(617) 625-6600 ext: 7900
133 Holland Street, Somerville, MA 02143
www.ParkSomerville.com

Application for a Handicapped Parking Space

ZA

Date: _____

Applicant Name: _____

Complete home address & zip code:

_____

_____

Phone: _____

Email: _____

License Plate #: _____

Name and complete home address of property owner.
(if same as applicant's, write "same")

_____

_____

_____

Application must include following:

- ☐ **Copy of Applicant's Driver License**
- ☐ **Copy of Applicant's Vehicle Registration**
- ☐ **Copy of Applicant's handicap placard**
- ☐ **Completed Health Care Provider information**
- ☐ **Letter from property owner (if applicable)**

ADDITIONAL INFORMATION:

- Handicapped spaces are available to those with permanent disabilities only.
- All outstanding parking tickets must be PAID before application is processed.
- Applicant must present copy of handicapped placard and documentation from health care provider.
- If a parking space is supplied for applicant's street, it can be used by all handicapped placard owners with proper residential permit.
- Spaces are valid for two years, after which time they need to be renewed.

ADDITIONAL QUESTIONS:

1) Does the property have a driveway (Yes/No)? _____

2) What is the width & number of vehicles driveway can hold?
   Width: _____ Number: _____

3) Are you a tenant (Yes/No)? _____

   a. Is off-street parking available (Yes/No)? _____
   (if not, provide written documentation from landlord)

4) Does your disability impair your mobility (Yes/No)? _____

a. Has a health care professional verified your disability (Yes/No)? _____

TO BE COMPLETED BY APPLICANT

I certify under the pains and penalties of perjury that all the information provided in this application, including the representation of my medical status and condition is true and correct to the best of my knowledge.

AUTHORIZATION TO RELEASE MEDICAL RECORDS - I hereby authorize the healthcare provider completing this form to discuss with and release any or all medical records pertaining to its content to the Traffic and Parking Department and its representatives.

Name of applicant: _____ **Signature:** _____

TO BE COMPLETED BY THE HEALTHCARE PROVIDER

Approval of a residential handicapped parking space is based upon information you provide. If your patient has an "invisible disability" or one that is not easily identifiable or verified by visual observation, it is incumbent upon you to specify the degree, level, and/or severity of functional impairment in order for the Traffic Commission and Disabilities Commission to make a fair evaluation. Handicapped parking spaces are only available for permanent disabilities.

Name of applicant: _____

Is the applicant's mobility impaired (Yes/No)? _____
If yes, how long will the mobility impairment last? Please specify weeks, months or years?

What is the approximate ambulatory range of the Applicant (in feet)? _____

Without rest? _____ With intermittent rest? _____

What is the prescribed ambulatory aide (walker, cane, etc…)?

Is there any permanent loss of limb or loss of use?

Please describe the functional disability which makes a handicapped parking space essential:

_____

_____

As a healthcare provider, I certify that I am a ___ Physician, ___Chiropractor, ___ Optometrist, ___ Podiatrist. In addition, I certify under pains and penalties of perjury that the information I have provided is true and correct.

Name of Provider: _____ **Signature:** _____

Practice Address: _____

License Number: _____ **Phone Number:** _____