

## 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 handicap placard and documentation from health care provider.
- If a parking space is supplied for applicant's street, it can be used by all handicap 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: \_\_\_\_\_