Borough of Marcus Hook

HANDICAPPED PARKING PERMIT APPLICATION
Application by Disabled Person

I certify that I am a disabled person as required by PA Statutes with certification from a physician, osteopathic physician, podiatrist, chiropractor licensed within the United States, the Division of Blind Services; or the Adjudication Office of the Veterans Administration.

1. _______________________________  _______________________________  _____________
   Name of Disabled Person  Signature of Disabled Person  Date Signed
   Parent or Guardian of Disabled Person

2. _______________________________
   Address
   Apt. # _______________

3. _______________________________
   Date of Birth
   Phone # _____________________

4. _______________________________
   License Number
   State _______

5. _______________________________
   Handicapped License Plate
   Yes ____________  No ____________

6. _______________________________
   Make of Vehicle
   Year ______________

7. _______________________________
   Number of Vehicle(s) currently registered at above address ___________

8. _____________________________________________________________________
   Nature of Handicap

9. Is Car Garage or Off-Street Parking Located at Above Address? Yes ____ No ____

10. Primary Street, Alley, Lane or Place where above vehicle is normally parked___________

11. Your handicapped parking permit application will not be processed without the following information:

   A. A signed physician's affidavit certifying to your medical condition. Use the Physician's Statement of Certification form attached to this application.

   B. Copy of current driver's license, vehicle registration and vehicle insurance currently in effect.

12. To clearly avoid any false impressions, be advised that any individual who applies and receives approval for a handicapped parking spot does not have exclusive use of the designated parking space. Other residents on the same street or any individual with a valid handicapped parking license plate cannot be denied the use of the handicapped parking space. Also under normal circumstances no more than one (1) handicapped parking space will be approved for each street unit block.

   APPLICANT MUST REAPPLY EVERY TWO (2) YEARS

10th & Green Streets  Marcus Hook, PA 19061  610-485-1341  610-485-9767 Fax
PHYSICIAN’S STATEMENT OF CERTIFICATION

This is to certify that ___________________________ is a disabled person with specific disability(ies) that limit or impair his/her ability to walk or is certified as legally blind. The specific disability(ies) as checked below are expected to last more than twelve (12) months.

_____ 1. Inability to walk 200 feet without stopping to rest.

_____ 2. Inability to walk without the use of or assistance from a brace, cane, crutch, prosthetic device, or other assistive device, or without assistance from another person. (If the assistive device significantly restores the person's ability to the extent that the person can walk without severe irritation the person is not eligible for the handicap parking spot.)

_____ 3. Permanently uses a wheelchair.

_____ 4. Restriction by lung disease to the extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than 1 liter, or the person's arterial oxygen is less that 60 mm/hg on room air at rest.

_____ 5. Use of portable oxygen.

_____ 6. Restriction by cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.

_____ 7. Severe limitation in the person's ability to walk due to an arthritic, neurological, or orthopedic condition.

_____ 8. Legally blind.

Name of Physician, Osteopathic Physician, Chiropractor, Division of Blind Services, Adjudication Office of the Veterans Administration

__________________________________________
Signature

__________________________________________
Date Signed

__________________________________________
Business Street Address

City, State, Zip Code

Certification or License No. of Physician, Osteopathic Physician, Podiatrist, Chiropractor.
TO BE COMPLETED BY APPLICANT

I verify that the facts set forth in this application are true and correct to the best of my knowledge, information and belief. This verification is based subject to the penalties of Section 4904 of the Crimes Code (10 Pa. C.S.A. 4904) relating to unsworn falsifications to authorities.

Print Name of Applicant

______________________________

Signature of Disabled Person,
Parent or Guardian of Disabled
Person

______________________________

Date Signed

DO NOT WRITE BELOW THIS LINE
FOR OFFICE USE ONLY

Mayor's Approval

______________________________

Signature

______________________________

Date

Mayor's Disapproval

______________________________

Signature

______________________________

Date

Council's Concurrence

______________________________

Signature

______________________________

Date

Date of Installation

______________________________