CITY OF WASHINGTON
55 West Maiden Street
Washington, PA 15301
724-223-4200 Option 1 Ext. 6
washington.cityclerk@gmail.com

APPLICATION FOR RESERVED ACCESSIBLE PARKING SPACE

APPLICANT MUST HAVE A PERSON WITH DISABILITY PARKING PLACARD OR LICENSE PLATE ISSUED BY THE COMMONWEALTH OF PA. PRIOR TO MAKING APPLICATION FOR RESERVED PARKING SPACE

NAME OF APPLICANT: ____

ADDRESS OF APPLICANT: ____

DATE OF BIRTH: _____________ PHONE NUMBER: _____________________________

EMAIL: _______________________________

WHEN DID THE SYMPTOMS FIRST APPEAR OR WHEN DID THE ACCIDENT OCCUR?

____

IS THE APPLICANT THE DRIVER OF THE VEHICLE? ______________________________

IF NOT, NAME OF THE PARENT OR MAIN DRIVER OF THE VEHICLE:

_________________________ RELATIONSHIP _____________________________________

DRIVERS PHONE: ________________ DRIVERS ADDRESS:_________________________

DESCRIPTION OF DISABILITY (please check where appropriate)

Wheelchair ______ frequently _______ on occasion

Crutches ______ frequently _______ on occasion

Cane ______ frequently _______ on occasion

Walker ______ frequently _______ on occasion

Length of comfortable walking distance: ____

Other impairment(s): ____

____

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Description of Vehicle and Parking Area (please check where appropriate)

Does the registered owner of the vehicle reside at the address of the applicant? (check one):

Yes ____ No _____

Pennsylvania-issued Persons with Disabilities license plate number

PD: _____________________ SDV: _____________________

Vehicle Information

Vehicle Make: __________________ Vehicle Model: ____________________

Color _________

Make sure to include a copy of the vehicle registration associated with this vehicle. The registration must be in your name or in the name of your primary live-in caregiver who resides full-time at the address on this application, and the address on the registration must match the one given on this application.

Parking Information (Check where applicable)

Street Parking ____________ Off-Street Parking ___________

Distance from your home to nearest parking space: _________________________________

Reason for request for the handicapped parking reserved street sign: _____________________

____

____

SIGNATURE OF APPLICANT: ____

SIGNATURE OF PARENT OR GUARDIAN (if under 21): _____________________________

I ACKNOWLEDGE THAT I AM AWARE THAT IT IS MY RESPONSIBILITY TO NOTIFY THE CITY CLERK IF I MOVE OR NO LONGER NEED THIS HANDICAP SIGN.

____
Signature

The application will be reviewed by City Council at the next Regular Council Meeting.

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PHYSICIAN'S STATEMENT

To be completed by Physician's Office

Name of Applicant: ____

Address of Applicant: ____

Physician's Description of patient's disability: ______________________________________

____

____

Name of Physician: ____

Address of Physician: ____

Phone Number of Physician: ____

Physician's Signature: ____

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CERTIFICATION FROM THE LANDLORD OR PROPERTY MANAGER

(Please complete, sign, and return this form to your tenant.)

I, (print name) ____, certify that I am the owner or property manager of the property at the following address: __________________________ __________________________.

I understand that my tenant, (print name) ____, has requested a Residential On-Street Parking Space for People with Disabilities from the City of Washington.

I certify that I cannot provide accessible off-street parking at this property. I understand that staff from the City may conduct a site visit to verify this statement.

Signature: ______________________________________

Printed Name __________________________________ Title______________________________

Owner, Mgr., Etc.

Phone Number: ________________________________

Email: _______________________________________

Date: ____