

Please Complete

APPLICATION FORM
HANDICAPPED PARKING SIGN
BOROUGH OF PEN ARGYL

NAME OF APPLICANT _____ ADDRESS _____

_____ ZIP CODE _____ PHONE _____

NAME OF DISABLED PERSON (IF OTHER THAN APPLICANT) _____ AGE _____

RELATIONSHIP TO APPLICANT _____

NATURE OF DISABILITY _____

DO YOU USE ASSISTIVE DEVICES FOR AMBULATION OR MOBILITY? (IE: WHEELCHAIR, CRUTCHES, WALKER) ____ Yes ____ No

IF YES, PLEASE DESCRIBE _____

DO YOU HAVE A VALID DRIVER'S LICENSE? DISABLED PERSON _____ OTHER (RELATIONSHIP) _____

DO YOU OWN A VEHICLE? DISABLED PERSON ____ OTHER (RELATIONSHIP) _____

LICENSE PLATE NUMBER _____

DO YOU HAVE A HP LICENSE PLATE OR DV LICENSE PLATE? ____ YES ____ No

DO YOU HAVE A HP PARKING PLACARD? ____ YES ____ No IF YES PLEASE INCLUDE COPY

IF YES, PLEASE GIVE REGISTRATION NUMBER OR CARD NUMBER _____

DO YOU HAVE ACCESS TO OFF-STREET PARKING? ____ Yes ____ No DO YOU HAVE ACCESS OR OWN A GARAGE? ____ Yes ____ No

ARE THERE PARKING RESTRICTIONS ON YOUR STREET? ____ Yes ____ No IF YES, PLEASE DESCRIBE _____

WILL YOU PARK YOUR VEHICLE AT THE DESIGNATED SPOT ON A REGULAR BASIS? ____ Yes ____ No

IF NO, PLEASE EXPLAIN _____

PLEASE GIVE YOUR PHYSICIAN'S NAME, ADDRESS AND PHONE NUMBER _____

PLEASE RETURN THIS FORM, ALONG WITH A STATEMENT FROM YOUR PHYSICIAN REGARDING THE NATURE OF YOUR DISABILITY TO:

ROBIN ZMODA, BOROUGH MANAGER
11 NORTH ROBINSON AVE
PEN ARGYL, PA 18072

UPON RECEIPT OF THIS APPLICATION FORM AND A PHYSICIAN'S STATEMENT, YOU WILL BE CONTACTED FOR A PERSONAL INTERVIEW REGARDING YOUR REQUEST.

SIGNATURE OF APPLICANT