City of New Kensington
Application for Handicapped Parking in Residential Area
Fee: $50.00 Make check payable to "City of New Kensington"

Applicant's Name: _____

Applicant's Address: _____

Applicant's Phone #: _____ _____
(Date of Application)

1. **TO BE COMPLETED BY APPLICANT**

   A. Do you possess a handicapped license or placard issued by the Commonwealth of Pennsylvania?
   Yes _____ No _____ If yes, plate/placard No.: _____

   B. Are you a resident of the City of New Kensington? _____

   C. Do you have accessible off-street parking in a driveway, parking pad or garage at your residence?
   Yes _____ No _____

   D. This is a **NEW** application _____; *OR* a **RENEWAL** _____

   E. **Any person bearing a handicapped or severely disabled veteran license plate or placard may also park in that space, and that space is <u>not reserved exclusively</u> for the individual who requested it.**

2. Applications must be accompanied by a completed copy of the attached Physician's Certificate for first-time applicants and for annual renewals.

3. Applicants with approved handicapped spaces must renew their applications each year during the month of October. Those who fail to renew their application will no longer be entitled to a handicapped parking space. If an applicant moves or passes away the City must be notified so that the parking sign can be removed.

_____
Applicant's Signature

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(FOR OFFICE USE ONLY)

Date of Application _____ Date of Site Inspection _____

APPROVED _____ DENIED _____

Application Fee Received on (Date): _____ Check no.: _____ Cash: _____

Work Order Issued Date: _____ By: _____

Sign Installed On: _____ Street Dept. Foreman Initials: _____

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PHYSICIAN'S CERTIFICATION

Applicant's Name: _____

I, the undersigned physician, do hereby certify that:

- I am a physician in good standing currently licensed to practice medicine in the Commonwealth of Pennsylvania.
- The above-named person (applicant) is currently under my care; and
- That the applicant (check all that apply):

_____Cannot walk a minimum of distance of 200 feet without stopping to rest.

_____ Is restricted to a wheelchair.

_____ Requires use of a walker and/or crutches.

_____ Is restricted by lung disease to such an extent that his/her forced expiratory volume for one second, when measured by spirometry, is less than one liter of the arterial oxygen tension is less than 60 MM/HG of room air at rest.

_____ Uses portable oxygen.

_____ Has a cardiac condition to the extent that his/her functional limitations are classified in severity as Class III of Class IV according to the standards set forth by the American Heart Association.

Physician's Name _____

Corporate Name (if different) _____

Type of Practice _____

Business Address _____

Business Telephone No. _____ Date _____

Physician's Signature _____