Andrew Hayman, Director
Department of Public Works

(610) 447-7742
FAX (610) 872-7896

HANDICAP PARKING ZONE APPLICATION

Please Write Legibly

Applicant's Name: _____

Applicant's Address: _____

Telephone #: (Home)_____ (Cell/Supplementary) _____

Check One: [] Handicapped Person [] Disabled Veteran

Do you operate a motor vehicle? [] Yes [] No

License State: _____ License Number: _____

Vehicle Year: _____ Vehicle Make and Model: _____

Is the applicant the driver of the vehicle? [] Yes [] No

If no, what is the relationship of the applicant to the driver? _____

The vehicle is owned by: _____

Address of vehicle owner: _____

City: _____ State: _____ Zip Code: _____

What is the relationship of the applicant to the vehicle owner? _____

(complete other side)

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

1. A copy of a valid **Pennsylvania Vehicle Registration**; valid **Pennsylvania Driver's License** evidencing that the applicant or the applicant's family member is the owner of the vehicle registered at the applicant's address;
2. Proof from PENNDOT that the vehicle has been issued a **handicapped license plate**; **or** that the applicant has a **handicapped placard and card** that verify the address;
3. And the applicant **must have his/her physician complete the physician's portion** of the enclosed application.

Upon approval of this application, you will be notified when to submit the twenty-five dollar ($25.00) fee. This special parking permit must be renewed annually. Each calendar year the applicant must comply with the request from the City to renew this special parking permit by submitting an annual fee of $25.00 along with proof that they remain eligible to retain the designated handicap space in the block where they reside.

To clearly avoid any false impressions, be advised that any individual who applies and receives approval for a handicapped parking space does not have exclusive use of the designated parking space. Any individual with a valid handicapped parking license plate (or placard) cannot be denied the use of the handicapped parking space.

I certify that I do not have off-street parking accommodations: [] Yes [] No

I certify that I have read and understand this form: [] Yes [] No

I further certify that I have answered all questions correctly to the best of my knowledge and I agree to abide by the terms of use if approved.

_____ _____

Signature of Applicant Date

PLEASE RETURN COMPLETED APPLICATION TO:

CHESTER CITY HALL
DEPT OF STREETS & PUBLIC IMPROVEMENTS
1 FOURTH STREET
CHESTER, PA 19013

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Department of Public Works

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HANDICAP PARKING ZONE APPLICATION

TO BE COMPLETED BY THE PROPERTY OWNER

Please Write Legibly

Property Owner's Name: _____

Property Owner's Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (Home)_____ (Cell/Supplementary) _____

I understand and affirm that the City of Chester is not responsible for any damages caused by the installation of the handicap sign, painting lines or any other additional work that I have requested during the process of appropriation.

_____ _____

Signature of Property Owner Date

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HANDICAP PARKING ZONE APPLICATION

TO BE COMPLETED BY FAMILY PHYSICIAN AND/OR MEDICAL SPECIALIST

Please Write Legibly

Applicant's Name: _____ Date: _____

Applicant's Address: _____

City: _____ State: _____ Zip Code: _____

The person named above has requested a HANDICAP PARKING ZONE in front of his/her residence. This is a special privilege granted by the City of Chester only to people who have severe physical disabilities. Such area will only be granted to those who cannot manage without it.

IS THE ABOVE APPLICANT DISABLED AND DO THEY QUALIFY FOR A HANDICAP PARKING ZONE?

[] YES [] NO [] OTHER

Please indicate the above applicant's disability:

_____

_____

_____

(***complete other side***)

Please describe disability in detail:

_____

_____

_____

Does the applicant need to be lifted in and out of the vehicle? **[]** YES **[]** NO

Can the above applicant walk more than one block without difficulty? **[]** YES **[]** NO

_____

Print Name of Family Physician:

_____

Signature of Family Physician:

Address: _____

Telephone #: _____

_____ _____

Print Name of Applicant **Telephone Number**

FOR OFFICE USE ONLY:

Council: *(circle one)* APPROVED DISAPPROVED

Date of Decision: _____

_____ _____

Signature: Director of Streets/Public Improvement Date