# BOROUGH of MILLVALE

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## ACCESSIBLE PARKING APPLICATION

*BOROUGH OF MILLVALE CODE CHAPTER 290 – ORDINANCE NO. 2505*

**FEES: ORIGINAL $50, RENEWAL $10, CHANGE OF ADDRESS $30**

**INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED**

| **APPLICATION DATE:** | | |
|---|---|---|
| CHECK ONE: ☐ ORIGINAL REQUEST | ☐ RENEWAL REQUEST | ☐ CHANGE OF ADDRESS |

| **APPLICANT INFORMATION** | | | |
|---|---|---|---|
| NAME OF PERSON WITH DISABILITY: | | OCCUPATION: | |
| DOB: | AGE: | SEX: ☐MALE | ☐ FEMALE |
| HOME ADDRESS: | | | |
| EMAIL: | PHONE #: | CELL PHONE #: | |
| DRIVER'S LICENSE / IDENTIFICATION #: | | STATE: | |

| **VEHICLE INFORMATION** | | | |
|---|---|---|---|
| DO YOU HAVE A DISABLED PLATE: | PLATE #: | | STATE: |
| DO YOU HAVE A DISABLED PLACARD: | PLACARD #: | STATE: | EXPIRATION DATE: |
| NAME OF PERSON PLATE/PLACARD ISSUED TOO: | | | |
| VEHICLE MAKE: | MODEL: | COLOR: | |

| **PROPERTY INFORMATION** | | | |
|---|---|---|---|
| EXPLAIN WHY YOU ARE IN NEED OF A PHYSICALLY DISABLED PARKING SPACE IN FRONT OF YOUR HOME: | | | |
| DO YOU HAVE A GARAGE OR OTHER OFF STREET PARKING AVAILABLE? | | | |
| IF YES, DESCRIBE WHY THIS SPACE CANNOT ACCOMMODATE YOUR NEEDS: | | | |
| ANTICIPATED TIME OF USE OF ON-STREET SPACE: | ☐FULLTIME | ☐DAYTIME ONLY | ☐NIGHTTIME ONLY |

| **APPLICATION CHECKLIST** | | |
|---|---|---|
| ☐ PROOF OF RESIDENCE | ☐ COPY OF DRIVER'S LICENSE | ☐ COPY OF VEHICLE REGISTRATION |
| ☐ COPY/PROOF OF VEHICLE INSURANCE | ☐ PHOTO OF PHYSICALLY DISABLED PLATE / PLACARD | |
| ☐ PHYSICIAN'S CERTIFICATION OF DISABILITY | ☐ ALL QUESTIONS ANSWERED | ☐ APPLICATION SIGNED |

**BY COMPLETING AND SUBMITTING THIS APPLICATION FOR APPROVAL**

# ACCESSIBLE PARKING APPLICATION

| I HEREBY STATE THE FOLLOWING | |
|---|---|
| • I STATE THAT I HAVE READ AND SIGNED THIS APPLICATION AFTER ITS COMPLETION, AND I SWEAR THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT, AND THAT ANY STATEMENT MADE ON OR PURSUANT TO THIS APPLICATION IS SUBJECT TO THE PENALTIES OF 18 PA.C.S. SECTION 4903 (A) (2) (RELATING TO FALSE SWEARING), WHICH SHALL INCLUDE PUNISHMENT OF A FINE NOT EXCEEDING $5,000, OR TO A TERM OR IMPRISONMENT OF NOT MORE THAN TWO YEARS, OR BOTH.<br>• I AGREE THAT IF I USE THIS ZONE FOR ANY PURPOSE OTHER THAN THAT WHICH I DESCRIBED IN THIS APPLICATION, THE ZONE WILL BE REMOVED.<br>• I UNDERSTAND THAT COMPLETING AND SUBMITTING THIS APPLICATION IS NOT APPROVAL OF A PERMIT.<br>• I AGREE THAT THE BOROUGH OF MILLVALE RETAINS THE RIGHT TO REMOVE THIS ZONE AT ANY TIME.<br>• I AM AWARE THAT IT IS MY RESPONSIBILITY TO FILE A COMPLETE APPLICATION. I UNDERSTAND THAT THE APPLICATION WILL BE RETURNED TO ME IF IT IS FOUND TO BE INCOMPLETE, ILLEGIBLE, OR OTHERWISE NOT FILED IN COMPLIANCE WITH THE INSTRUCTIONS.<br>• I AM FULLY AWARE THAT THE BOROUGH OF MILLVALE HAS THE RIGHT TO CONTACT MY PHYSICIAN AS LISTED ON THE APPLICATION.<br>• A RESERVED PHYSICALLY DISABLED PARKING SPACE IN FRONT OF A RESIDENCE IS A SPECIAL PRIVILEGE GRANTED BY THE BOROUGH OF MILLVALE ONLY TO PEOPLE WHO HAVE SEVERE PHYSICAL DISABILITIES. SUCH A SPACE WILL BE GRANTED ONLY TO THOSE WHO ARE MOBILITY IMPAIRED TO THE EXTENT THAT THEY CANNOT MANAGE WITHOUT IT. HOWEVER, THIS RESERVED PARKING ZONE DOES NOT SOLELY BELONG TO THE APPLICANT. ANYONE WITH A PHYSICALLY DISABLED LICENSE PLATE OR PHYSICALLY DISABLED PARKING PLACARD IS ELIGIBLE TO PARK IN THE ZONE. THESE ZONES WILL BE REVIEWED EVERY YEAR. | |
| **APPLICANT SIGNATURE:** | **DATE:** |

| BOROUGH OF MILLVALE USE ONLY | | |
|---|---|---|
| RECEIVED BY: | DATE RECEIVED: | FEE: |
| □ APPLICATION SIGNED | □ PHYSICIAN'S CERTIFICATION OF DISABILITY | □ ALL QUESTIONS ANSWERED |
| □ LICENSE RECEIVED | □ COPY/PROOF OF VEHICLE INSURANCE | □ COPY OF VEHICLE REGISTRATION RECEIVED |
| □ PHOTO OF PHYSICALLY DISABLED PLATE / PLACARD RECEIVED | | □ PROOF OF RESIDENCE RECEIVED |
| BOROUGH MANAGER APPROVAL: | DATE: | |
| PUBLIC WORKS APPROVAL: | DATE: | |
| POLICE APPROVAL: | DATE: | |
| DEFICINCIES: | | |
| SIGN ID: | DATE INSTALED: | INSTALLED BY: |

# ACCESSIBLE PARKING APPLICATION

## PHYSICIAN CERTIFICATION

(To be completed by a PENNSYLVANIA licensed medical physician)

The purpose of this program is to provide reserved residential on street parking to applicant's whose mobility is limited to such a degree, by one or more medical conditions, that parking is required to allow the applicant to continue to function independently. A Borough of Millvale chosen physician may review applications.

NAME OF PERSON WITH DISABILITY:

HOME ADDRESS:

THE UNDERSIGNED HEREBY CERTIFIES AS FOLLOWS

I EXAMINED THE ABOVE NAMED APPLICANT ON: (DATE)

DISABILITY CONDITION:

| | |
|---|---|
| ☐ HAS LIMITED OR NO USE OF ONE OR BOTH LOWER LIMBS; | ☐ A LEGALLY BLIND PERSON |

☐HAS A NEURO-MUSCULAR DYSFUNCTION THAT SEVERELY LIMITS MOBILITY;

☐HAS A PHYSICAL OR MENTAL IMPAIRMENT OF CONDITION THAT IS OTHER THAN THOSE SPECIFIED ABOVE;

PLEASE SPECIFY DATE OF ONSET OF APPLICANT'S DISABILITY:

PLEASE DESCRIBE IN DETAIL THE NATURE AND EXTENT OF THE APPLICANT'S DISABILITY:

PHYSICAL EXAMINATION FINDINGS PERTINENT TO THE APPLICANT'S MOBILITY:

I PERFORMED THE FOLLOWING TEST(S)/PROCEDURES DIAGNOSING THE APPLICANT'S DISABILITY:

| | | | |
|---|---|---|---|
| PLEASE SPECIFY THE PROGNOSIS: | | □ PERMANENT | □ TEMPORARY |
| WILL APPLICANT'S CURRENT LEVEL OF DISABILITY (CIRCLE ONE): | □ IMPROVE | □ REMAIN THE SAME | □ DETERIORATE |

DOES THE APPLICANT REQUIRE THE USE OF ANY OF THE FOLLOWING MOBILITY AIDS? (CHECK ALL THAT APPLY)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| □ CRUTCHES | □ SCOOTER | □ CANE(S) | □ WALKER | □ ARTIFICIAL LIMBS | □ WHEELCHAIR | □ BRACES | □ OXYGEN |

□ NONE □ OTHER (specify)

| | | |
|---|---|---|
| DOES APPLICANT REQUIRE ASSISTANCE IN ENTERING OR EXITING VEHICLE OR RESIDENCE? | □ YES | □ NO |
| IS THE APPLICANT CAPABLE OF DRIVING? | □ YES | □ NO |

I AM A BOARD CERTIFIED PHYSICIAN IN THE FOLLOWING AREAS:

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT FALSE STATEMENTS MADE HEREIN ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. SEC. 4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

| | |
|---|---|
| PHYSICIAN SIGNATURE: | DATE: |
| PRINTED NAME: | PHYSICIAN'S LICENSE# |
| ADDRESS: | PHONE # |

**ANY QUESTIONS NOT ANSWERED ON THIS APPLICATION MAY RESULT IN IT BEING RETURNED TO THE APPLICANT OR DENIED.**