City of Butler
Application for Handicapped Parking in Residential Area

Applicant's Name:_____

Applicant's Address:_____

Applicant's Phone No.:_____ _____
(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 Butler:_____

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 **RENWAL**_____.

2. Applications must be accompanied by a completed copy of the attached physician's certificate for firs-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_____ Streets 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 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_____