# CITY OF CAMBRIDGE
## Traffic, Parking and Transportation

344 Broadway
Cambridge, Massachusetts 02139

Susan E. Clippinger
Director
(617) 349-4700

Wayne S. Amaral
Traffic Operations Manager
(617) 349-4723

## DESIGNATED DISABILITY PARKING SPACE APPLICATION

**08/05/2004**

**Applicant's Name: First** _____ **Last** _____

**Applicant's Street Address:** _____ **Cambridge, MA ZipCode: 02138**

**Phone Numbers:** _____ **(e.g. (617) 555-0000)**

**Vehicle Registration Number:** _____ **Placard Number:** _____

You must provide a written statement from the owner of your home that you have either no off-street parking where you live, or of why the available off-street parking is inadequate or unavailable. (Both are subject to verification.)

_____

_____

_____

_____

_____

_____

_____

_____(Use the back if you need more space.)

I have read the City of Cambridge policy for establishing designated disability parking spaces on public streets in residential areas, and I understand the conditions required for a designated handicap parking space. I also understand that if I fail to meet the eligibility requirements, I will have the opportunity to appeal for a waiver.

I certify that the information provided is correct. I also give permission for the Cambridge Commission for Persons with Disabilities or Cambridge Traffic, Parking and Transportation to obtain all information necessary to verify my need for this designated disability parking space.

**Date:**_____ **Signature:**_____

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## City of Cambridge Traffic, Parking and Transportation Department
## Request for Designated Disability Parking Space

Applicant's Name: First _____ Last _____

Applicant's Street Address: _____ **Cambridge, MA 02138**

**TO BE COMPLETED BY ATTENDING PHYSICIAN or OTHER HEALTHCARE PROFESSIONAL**

**To Physician**: Approval for a Residential Designated Disability Parking Space is based in part on information provided by you. If this applicant (your patient) has a "hidden" disability (i.e.: one that is not visibly obvious), it will be incumbent on you to specify the extent to which the disability limits the person's mobility in order for our Review Committee to make a fair evaluation of this application. Residential Designated Disability Parking Spaces are available only to those with substantial functional limitations that affect mobility for more than **six months**.

**Please answer the following:**

Does the applicant have mobility impairment? ❑ No ❑ Yes

Note which, if any, of the following impairments is attributable to the applicant and explain:

- ❑ Loss of use of one or more limbs _____
- ❑ Vision impairment _____
- ❑ Knee, ankle, hip dysfunction _____
- ❑ Respiratory, heart or circulatory disorder _____

Are mobility aids prescribed? ❑ No ❑ Yes; please specify: ❑ cane ❑ crutches ❑ walker ❑ wheelchair

Ambulatory range of the applicant: Without rest _____ distance in feet
With intermittent rest _____ distance in feet

Describe any other functional limitations that make having a Residential Handicap Parking Space desirable:

_____

_____

Physicians name (please print): _____ Phone: _____

Medical specialty: _____ Registration Number:_____

Address: _____

**I hereby certify that the above information is correct**.

Date _____ Physician's signature _____

**PLEASE MAIL TO:**

Cambridge Traffic, Parking and Transportation Department
ATTN: Wayne S. Amaral
344 Broadway
Cambridge, MA 02139