Borough of Bowmanstown

490 Ore Street ~ PO Box 127
Bowmanstown, PA 18030-0127
Phone 610-852-2455
Fax 610-852-2444
bborough@ptd.net

INSTRUCTIONS:

1. COMPLETE THE ATTACHED APPLICATION.

2. ATTACH COPIES OF THE DOCUMENTS LISTED IN THE ATTACHED APPLICATION.

3. APPLICANTS MUST HAVE THEIR PHYSICIAN COMPLETE PAGE 3

4. UPON APPROVAL THE APPLICANT SHALL PAY AN ADMINISTRATIVE FEE OF ONE HUNDRED DOLLAR ($100.00) BY CHECK OR MONEY ORDER PAYABLE TO THE BOROUGH OF BOWMANSTOWN.

5. APPLICATION MUST BE RENEWED YEARLY BETWEEN JANUARY 1ST AND JANUARY 31ST AT A FEE OF TEN DOLLAR ($10.00)

6. MAIL OR DROP OFF AT:

BOROUGH OF BOWMANSTOWN
490 ORE STREET
PO BOX 127
BOWMANSTOWN, PA 18030

7. APPLICATIONS THAT ARE NOT COMPLETED PROPERLY WILL BE RETURNED.

8. APPLICANTS MUST PROVIDE THIS OFFICE WITH ALL NECESSARY COPIES.

9. APPLICANTS WITH ACCESS TO A DRIVEWAY, GARAGE, AND/OR OTHER OFF-STREET PARKING ARE NOT ENTITLED TO A HANDICAP PARKING SPACE.

DETERMINATION:
All applications shall be reviewed and approved by Chairman of Streets or Council President. Once the application is approved, our Public Works Department will install a disabled parking sign in front of the property indicated on this application.

Borough of Bowmanstown

490 Ore Street ~ PO Box 127
Bowmanstown, PA 18030-0127
Phone 610-852-2455
Fax 610-852-2444
bborough@ptd.net

APPLICATION FOR RESERVED RESIDENTIAL PARKING FOR PEOPLE WITH DISABILITIES

DATE:_____

NAME:_____

ADDRESS:_____

PHONE:_____ **CELL:**_____

OCCUPATION:_____ **RETIRED? [ ] YES [ ] NO**

ACCESS TO: DRIVEWAY [ ] YES [ ] NO
GARAGE [ ] YES [ ] NO
OFF-STREET PARKING [ ] YES [ ] NO

HANDICAPPED LICENSE PLATE #_____

HANDICAPPED PLACARD#_____ **EXP DATE**_____
(If you have a handicapped licensed plate, you MUST include a copy of the vehicle owner's registration card. If you have a disability parking placard, you MUST provide a copy of the disability parking placard with your application)

VEHICLE MAKE & MODEL:_____ **YEAR:**_____

ARE YOU THE PRIMARY OPERATOR OF THIS VEHICLE? [ ] YES [ ] NO

If No, who are you dependent on for transportation? _____

By signing below you declare that you have not willingly or knowingly made a false statement or given information which you know to be false.

_____
Signature of Person with Disability

_____
Signature of Applicant ***(if different from above)***

Borough of Bowmanstown
490 Ore Street ~ PO Box 127
Bowmanstown, PA 18030-0127
Phone 610-852-2455
Fax 610-852-2444
bborough@ptd.net

PHYSICIAN'S CERTIFICATION OF DISABILITY
(To be completed by your physician)

NAME OF APPLICANT:_____

NAME OF PHYSICIAN:_____

OFFICE ADDRESS:_____

OFFICE PHONE:_____

DISABILITY STATUS:

- ❑ Impaired or Non Ambulatory Disability
- ❑ Arthritis
- ❑ Amputation / Level and Site
- ❑ Cerebrovascular Accident
- ❑ Pulmonary
- ❑ Cardiovascular
- ❑ Neurological
- ❑ Other *(please specify)*:_____

Does the applicant need to be lifted in or out of their vehicle? [ ] YES [ ] NO
Is the applicant capable of driving? [ ] YES [ ] NO
Does the applicant medically require the use of portable oxygen? [ ] YES [ ] NO
Does the applicant have limited or no use of one or both legs? [ ] YES [ ] NO
Does the applicant's physical or mental impairment prevent them from being able to walk a distance of 200 feet without stopping? [ ] YES [ ] NO

_____ _____
Physician's Signature Date