JIM THORPE POLICE DEPARTMENT
HANDI-CAP PARKING SIGN APPLICATION

Please read the attached application carefully. Complete this form, and return it along with a copy of your driver's license, vehicle registration and handi-cap plate number or placard when applicable. A check in the amount of **$250.00** will be needed once the Jim Thorpe Police department and council approve the application. Submit your application to:

JIM THORPE BOROUGH OFFICE
JIM THORPE POLICE DEPARTMENT
101 EAST TENTH STREET
JIM THORPE, PA. 18229

Attached is a form which must be completed by your physician, certifying the nature of your disability. This form must be completed and accompany the application

To qualify for handi-cap parking the following criteria must be met:

1. Applicant and/or disabled person must reside at the address to which the vehicle is registered.

2. Vehicle must have one of the following issued by the State of Pennsylvania:

    a. Handi-cap License Plate
    b. Severely Disabled Veteran handi-cap License Plate
    c. Handi-cap Parking Placard

3. Applicant and/or disabled person cannot have off-street parking available, garage, driveway, etc.

4. The disabled person must have a disability that strictly restricts ambulatory.

5. Applicant must pay a $250.00 fee for the sign.

6. Applicant must pay an annual renewal fee of $30.00

** Please Note*They Physician's report **MUST BE PRINTED OR TYPED** to be clearly read, or application will be returned without approval.
This is a non-personalized handi-cap parking space.

APPLICANT AND/OR DISABLED PERSON MUST SUBMIT A COPY OF THEIR DRIVER'S LICENSE, VEHICLE REGISTRATION AND HANDI-CAP PLACARD (WHEN APPLICABLE) AND A CHECK IN THE AMOUNT OF $250.00 FOR THE SIGN.

APPLICANT INFORMATION

Name of Applicant:_____ Phone #:_____
(print clearly)

Address:_____

Is Applicant disabled? Yes ( ) No ( ) (please check one)

If NO, name of disabled person:_____
(print clearly)

_____

VEHICLE INFORMATION

License Plate #_____ Handi-cap Placard#_____

Is driver of the vehicle disabled? Yes ( ) No ( ) (please check one)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. What is the nature of your disability?_____

   _____

   _____

2. Explain why you feel you need a handi-cap parking space:_____

   _____

   _____

3. Do you use one of the following? (please check)

a. Wheelchair	( )	d. Cane	( )	g. N/A	( )
b. Crutches	( )	e. Braces	( )		
c. Walker	( )	f. Other	( )	Please specify below	

_____

4. Do you have off street parking? Yes ( ) No ( )
   If yes please check Garage ( ) Driveway ( )

5. Are there any type of parking restrictions on your street? Yes ( ) No ( )

   If yes, please describe:_____

   _____

APPLICATION INFORMATION

6. Do you rent the property where you are residing? Yes ( ) No ( )

7. If yes, your landlord will need to sign below:

Property Manager's Name & Address:_________

Phone #_____ Date:_____

This notes that you have no objection to the Borough of Jim Thorpe installing a handicap sign for your tenant along the public sidewalk in front of the property at the above address.

I hereby certify that all of the information on this application is true and correct to the best of my knowledge. I further agree that if I use this zone in any other manner other than that which I described at the time of this application; the zone will be removed. In addition, I agree that the Borough of Jim Thorpe retains the rights to remove this zone at any time.

Applicant's signature Date

Note: It is a crime to give false or misleading information on this application. Falsification could lead to the imposition of fines as provided for in paragraph 3354 (E) of the Vehicle Code, 75 PA. C.S.A., together with the costs of prosecution.

PHYSICIAN'S STATEMENT MUST BE PRINTED OR TYPED

Policy Statement – A reserved parking space in front of a residence is a special privilege granted by the Borough of Jim Thorpe. Only to people who have severe physical disabilities. Such space will only be granted to those who cannot manage without it.

Patients Name:_____ Age:_____

1. Please indicate the patients diagnosis:_____

   _____

2. Please describe in detail why you feel applicant should have reserved handi-cap parking:

   _____

   _____

3. If the applicant's diagnosis is heart disease, please check the below classification:

   ( ) Class I — Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpation, dyspnea, or angina pain.

   ( ) Class II — Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpation, dyspnea, or angina pain.

   ( ) Class III — Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity. Causes fatigue, palpitation, or angina pain.

   ( ) Class IV — Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the angina syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

4. Is the patient restricted by lung disease? Yes ( ) No ( )

   a. If yes, is patient restricted to the extent that the patient's forced (respiratory) Expiratory volume for one second when measured by spirometry, is less than One liter or the arterial oxygen tension is less than 60 mm/hg on room air at Rest?

      ( ) Yes ( ) No

   b. Uses portable oxygen? ( ) Yes ( ) No

PHYSICIAN'S STATEMENT (CONTINUED)

5. Can the applicant walk more than 200 feet without stopping to rest? ( ) Yes ( ) No

6. Is the patient's disability permanent? ( ) Yes ( ) No

   If no, what is the patient's prognosis for recovery?_____

   _____

   _____

7. Does the patient drive a motor vehicle? ( ) Yes ( ) No

8. Can the patient walk up or down steps without difficulty? ( ) Yes ( ) No

9. Does the patient walk with the assistance of a cane, crutch, prosthetic devise, brace or other assistance device? ( ) Yes ( ) No

COMMENTS: _____

_____

_____

Physician's Name:_____

Address:_____ Phone #:_____

Physician's Signature:_____ Date:_____