APPLICATION FOR MARKED AS RESERVED FOR DISABLED PARKING ONLY ON RESIDENTIAL STREET

CITY OF COLUMBIA PUBLIC WORKS DEPARTMENT
701 East Broadway
P.O. Box 6015
Columbia, MO 65205
573-874-7250

If a parent, guardian or spouse is filling out this application for a child or relative, please list the child or relative as the applicant.

Applicant's Name: _____E-mail: _____

Telephone Number: _____ Date of Birth: _____

I am requesting a disabled parking space be considered for the following residential street:

Street Address: _____

City: _____ Zip Code: _____

I have lived at this address for _____ years.

_____ Yes _____ No (1) I am the current owner at this address.

_____ Yes _____ No (2) I am NOT the current owner of this address, but the owner is aware of this request and has no objection to it.
If yes, Owner/Landlord must sign:

X _____ _____
Print Owner/Landlord's Name Telephone Number

X _____ _____
Owner/Landlord's Signature Date

_____ Yes _____ No (3) There is at least twenty (20) feet of space in front of the above listed property for a disabled parking space.

_____ Yes _____ No (4) There is NOT twenty (20) feet of space in front of the above listed property for a disabled parking space, but the owners of the abutting property are aware of this request and have no objection to it.
If yes, Owner/Landlord of the abutting property must sign:

X _____ _____
Print Owner/Landlord's Name Telephone Number

X _____ _____
Owner/Landlord's Signature Date

X _____
Abutted Property Address

_____ Yes _____ No (5) I do not have off-street parking available to me at this address (off-street parking includes a garage, driveway or carport).

_____ Yes _____ No (6) There is off-street parking at this address, however due to my disability it is impractical because:

_____

_____

_____

_____ Yes _____ No (7) I have a disability which limits or impairs the ability to walk as defined in City Code 14-441:

"Any natural person with disabilities which limit or impair the ability to walk, as determined by a licensed physician as follows:

(1) The person cannot walk fifty (50) feet without stopping to rest; or

(2) The person cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device; or

(3) Is restricted by lung disease to such an extent that the person's forced respiratory expiratory volume for one second, when measured by spirometry, is less than one (1) liter, or the arterial oxygen tension is less than sixty (60) mm/hg on room air at rest; or

(4) Uses portable oxygen; or

(5) Has a cardiac condition to the extent that the person's functional limitations are classified in severity as class III or class IV according to standards set by the American Heart Association; or

(6) Is severely limited in his ability to walk due to an arthritic, neurological, or orthopedic condition."

_____ Yes _____ No (8) I have a vehicle registered to the applicant and that vehicle may lawfully park in disabled parking spaces.

If <u>yes</u>, attach the following to this application:

- **Vehicle registration information from the Missouri Department of Revenue (or out-of-state equivalent).**
- **Include proof that vehicle may lawfully park in designated disabled parking spaces (placard receipt, disabled license plate registration, or letter, all from the Missouri Department of Revenue (or out-of-state equivalent).**

_____ Yes _____ No (9) I do NOT drive myself, but I rely on someone who lives with me full time for transportation and that person has registered vehicle which may lawfully park in disabled parking spaces.

If <u>yes</u>, attach copy of the following to this application:

- **Include driver's vehicle registration information and proof the vehicle may lawfully park in designated disabled parking spaces.**

X _____ _____

Print Driver's Name Telephone Number

X _____ _____

Driver's Signature Date

APPLICANT CERTIFICATION

I hereby certify that the information provided above is true and correct to the best of my knowledge and belief. I understand that falsification of information may result in a denial of this application and that any false statements made herein are subject to potential prosecution under Columbia City Ordinance §16-193.

I understand that this is only an application and that the City of Columbia Public Works Department has the right to deny or approve this application at their discretion. The factors upon which Public Works will base their determination include, but are not necessarily limited to, the following: right of way requirements for the street and the practicality of installing a disabled parking spot in any given location (including considerations such as no parking zones, fire hydrants, proximity to stop signs or crosswalks, etc.), expected amount of use of the parking spot, available parking on that street and alternative options available; as well as, the degree that the impairment or limitation is reduced and the benefit to the applicant.

If this application is approved and a disabled space is installed, I understand that I have a responsibility to notify the City of Columbia Public Works Department if I change residences. I also understand that Public Works reserves the right to remove the parking spot at any time and for any reason. I understand that this parking space is a public parking space and it is not solely for my use as the applicant.

_____

Applicant's Signature Date

If this application was prepared by someone other than the applicant, please sign above and provide the information below:

Name:_____ Address:_____

City: _____State:_____ Zip Code: _____Phone Number: _____

Relationship: _____

PHYSICIAN'S CERTIFICATION OF APPLICANT INFORMATION
Residential Parking for People with Disabilities Program
Application for Disabled Parking Zone near Residence

In order to allow the City of Columbia to evaluate your request, this professional verification section must be completed. Please contact a physician to confirm the information you have provided**. THIS PORTION MUST BE COMPLETED BY A LICENSED PHYSICIAN.** Please complete the following information and authorization form.

PROFESSIONAL VERIFICATION FOR:

_____
Print Patient's Name

Required Information (Failure to provide information may cause a delay in the application process):

Please describe the nature and extent of the applicant's disability. (FOCUS ON MOBILITY LIMITATIONS)
_____
_____
_____

_____ Yes _____ No (1) Is the applicant able to walk fifty (50) feet without stopping to rest?

_____ Yes _____ No (2) Is the applicant able to walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device?

_____ Yes _____ No (3) Is the applicant restricted by lung disease to such an extent that the person's forced respiratory expiratory volume for one (1) second, when measured by spirometry, is less than one (1) liter, or the arterial oxygen tension is less than sixty (60) mm/hg on room air at rest?

_____ Yes _____ No (4) Does the applicant use portable oxygen?

_____ Yes _____ No (5) Has a cardiac condition to the extent that the person's functional limitations are classified in severity as class III or class IV according to standards set by the American Heart Association?

_____ Yes _____ No (6) Is the applicant severely limited in his or her ability to walk due to an arthritic, neurological, or orthopedic condition?

If the answer to all of the above questions is no, is there another reason why this person would benefit from a disabled parking space in front of their residence? Please explain.
_____
_____
_____
_____

<u>Professional's Information (Please Print):</u>
Medical Professional Associated With: _____
Name: _____
Title:_____
Address:_____
City: _____ State:_____ Zip Code: _____
Phone Number: _____

Signature below indicates that I certify that the information above is true according to the best of my knowledge and belief.

Signed: _____Date: _____