APPLICATION FOR HANDICAPPED STREET PARKING SIGN

NAME _____ AGE _____ DATE OF BIRTH_____

ADDRESS _____ APT # _____

HOME PHONE _____ CELL _____ WORK _____

OHIO HANDICAPPED PLACARD/CARD # _____ EXPIRES _____

MY HANDICAP IS _____

YOU HAVE MY PERMISSION TO CONTACT MY PERSONAL PHYSICIAN LISTED BELOW IN REGARD TO THE ABOVE-MENTIONED HANDICAP.

DR. _____

ADDRESS _____

_____

_____ _____

SIGNATURE OF HANDICAPPED PERSON OR NEXT-OF-KIN

RELATIONSHIP IF SIGNED BY NEXT-OF-KIN

DATE _____

RETURN TO: NORWOOD CITY HEALTH DEPARTMENT
2059 SHERMAN AVENUE
NORWOOD, OHIO 45212