

## 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