



DEREK ARMSTEAD
MAYOR

City of Linden

Union County, New Jersey
Department Of Police – Traffic Bureau
City Hall - 301 North Wood Avenue
Linden, New Jersey 07036
(908)474-8505



DAVID HART
CHIEF OF POLICE

Application for Handicap Parking Space

Dear Applicant:

Enclosed, please find an application for an On-Street Handicapped Parking Space. It is very important that this application be filled out completely and legibly. An application that is incomplete, illegible or otherwise not filled out in compliance with the explicit instructions given on the application will be returned to the applicant without action.

Also attached is a form that must be completed by your physician, certifying the nature of your disability. This form must be printed or typed and returned with the completed application.

Upon our receipt and verification of your completed application, a representative of the Linden Police Department Traffic Bureau will contact you. At that time, an appointment will be made to come to your home for an in-person interview and to survey parking as it applies to your particular situation.

You will be notified in writing as to whether your application has been approved or denied.



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On-Street Handicapped Parking Space Criteria

Criteria: In order for an application for an on-street Handicapped Parking space to be approved, the following conditions must be met:

1. The applicant is a resident of the City of Linden and is permanently disabled, or will be disabled for a period of time exceeding 1 year, or resides with a Person who is permanently disabled or will be disabled for a period of time exceeding 1 year and the applicant is responsible for his or her transportation; and
2. The applicant must be able to show that the disabled person's mobility is impaired to the extent that ambulation is severely restricted; and
3. The requested location is on a public street; and
4. The applicant resides at the address where the on-street Handicapped Parking space is requested; and
5. The applicant supplies the vehicle's license plate number and/or handicapped placard number with expiration date for verification; and
6. The applicant, or resident being cared for, has a currently valid Handicap Registration plate on their vehicle, or has been issued a currently valid Handicap Placard; and
7. The applicant must be able to demonstrate that off-street parking is inaccessible; and
8. The requested on-street Handicapped Parking space must be installed in front of the property of the applicant's property, unless deemed unfeasible by the City, and then such space should be placed as near to the requested property as possible; and
9. The requested parking space does not conflict with any parking restriction already in place and the parking width on front of the residence is at least 22 feet; and
10. The applicant agrees to advise the City of Linden Police Department when the Handicapped space is no longer required.

**** Please Note: Applicants will not be approved for a handicap parking space if there is a garage or driveway, regardless if the garage is rented out or filled with storage, and/or if the driveway is occupied by family cars. ****



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Application for Handicapped Parking Space

If this application is being completed by someone other than the Handicapped Person, please list that person's name below: (Please Print)

_____ Relationship to Applicant
Person Completing Application

Contact Information on Person Completing Application:

_____ Street
Address City State Zip

_____ Home Phone Mobile Phone
Email Address

Disabled Person's Name:

The following information required on this application must pertain to the above mentioned Disabled Person.

Address _____ Telephone _____

Please answer the following questions completely:

1. Is the Applicant a resident of the City of Linden?
 Yes No
2. Have you ever applied for a handicapped parking space before? If yes, approximately when and where you denied?



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3. Is the Applicant:

- Permanently Disabled?; or
- Disabled for period of 1 year or more?; or
- A person who resides with the Permanently Disabled Person, or resides with a Disabled Person who is disabled for a period of 1 year or more?

4. Explain why you are in need of a Handicapped Parking Space in front of your house.

5. Do you have garage or other off street parking available?

- Yes No

If yes, please identify what type of off street parking you have, and explain why you believe that available off street parking is unusable:

6. Does the disable person have a Handicapped License Plate? If Yes, License Plate Number and State:

_____ If

- No, does the disable person have a Handicapped Placard? YES – Placard Number:
- NO



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7. If the vehicle is not registered to the Handicapped Person, why is a Handicapped Parking Space being requested? Please be specific:

8. Are there any types of Parking Restrictions on your street?

- No
- Yes

If yes, Please describe:

9. Do you rent the property where you are residing? No

- Yes – If yes, your landlord will have to sign below.
-

I, _____, certify that I am the owner or Property Manager of (address) _____ and that I have no objection to the City of Linden installing a Handicapped Parking sign for my tenant along the public sidewalk in front of the property at the above address.

Landlord or Property Manager's Signature	Phone Number	Date
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10. Please list any and all vehicles registered at this residence:

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____



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Applicant's Certification

I am aware that it is my responsibility to file a complete application. I understand that the application will be returned to me if it is found to be incomplete, illegible, or otherwise not filed in compliance with the instructions.

I understand that if I use this Handicapped Parking Space in any manner other than that which I described at the time of this application, the space will be removed. In addition, I agree that the City of Linden retains the right to remove this Handicapped Parking Space at any time.

I further understand that it is my responsibility to promptly notify the City of Linden should I no longer need the Handicapped Parking Space.

I acknowledge that, should my request for a Handicapped Parking Space be denied, that I may appeal the decision to deny my request to the Council of the City of Linden. I understand that this appeal must be in writing and submitted within 30 days from my receipt of notice of denial.

I certify that the information contained herein is true and correct to the best of my knowledge and belief. I understand that any false statements made herein are subject to the penalties of 2C:21-4 of the New Jersey Criminal Code, relating to making a false statement or providing misinformation on an application.

Applicant's Signature

Date



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Physician's Certification of Disability

Policy Statement

All portions of this form must be filled out in detail by the disabled person's treating physician based on an examination conducted within the past six months. A Handicapped Parking Space in front of a residence is a special privilege granted by the City of Linden only to people who have severe physical disabilities. Such a space will be granted only to those who are mobility impaired to the extent that they cannot manage without the Handicapped Parking Space.

Please TYPE or PRINT CLEARLY or application will be rejected

Patient's Name: _____

Residential Address: _____

City: _____ State: _____ Zip: _____

Home Telephone Number: _____

The undersigned hereby certifies as follows:

1. I have examined the above named individual on _____
2. Disability Status (Please check all that apply, refer to the attached functional guidelines)

- Permanently Disabled
- Disabled for 1 year or more Other/Please
- Specify:



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3. Does the individual **require** the use of any devices such as wheelchair or crutches to ambulate?
 YES NO

If yes, list said devices:

4. By signing this document, I certify that:

1. The individual's mobility is impaired to the extent that the ambulation is severely restricted; and
2. The individual is permanently disabled or will be disabled for a period of time exceeding 1 year; and
3. The information contained herein is true and correct to the best of my knowledge and belief. I understand that false statements made herein are subject to the penalties of 2C:214 of the New Jersey Criminal Code, relating to making a false statement or providing misinformation on an application.

Signature _____ Date _____

Please Print:

Physician's Name: _____

Address: _____

City and State: _____ Zip Code: _____

Telephone Number: _____

License Number: _____