T O W N o f B R O O K L I N E
Massachusetts
Department of Public Works
Engineering & Transportation Division

Application for Designated Curbside Disabled Parking Space

Applicant's Name: First: _____ Last: _____

Applicant's Street Address: _____ Brookline, MA _____

TO BE COMPLETED BY ATTENDING PHYSICIAN or OTHER HEALTHCARE PROFESSIONAL

To Physician: Approval for a Designated Curbside Disability Parking Space is based in part on information provided by you. If this applicant (your patient) has a "hidden" disability (i.e.: one that is not visibly obvious), it will be incumbent on you to specify the extent to which the disability limits the person's mobility in order for our Review Committee to make a fair evaluation of this application. Designated Curbside Disability Parking Spaces are available only to those with substantial functional limitations that affect mobility for more than six months.

Please answer the following:

Does the applicant have mobility impairment? □ No □ Yes

Note which, if any, of the following impairments is attributable to the applicant and explain:

- Loss of use of one or more limbs
- Vision impairment
- Knee, ankle, hip dysfunction
- Respiratory, heart or circulatory disorder

Are mobility aids prescribed? □ No □ Yes;
please specify: □ cane □ crutches □ walker □ wheelchair
Ambulatory range of the applicant: Without rest: _____distance in feet
With intermittent rest: _____distance in feet

Describe any other functional limitations that make having a Designated Curbside Disability Parking Space desirable:

Physicians name (please print):_____ Phone:_____
Medical specialty:_____ Registration Number:_____
Address:_____

I hereby certify that the above information is correct.

Physician's signature: _____ Date: _____

PLEASE MAIL TO: Transportation Division 333 Washington Street Brookline, MA 02445

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DESIGNATED CURBSIDE DISABLED PARKING SPACE APPLICATION

(To be completed by applicant)

Applicant's Name: First: _____ Last: _____

Applicant's Street Address: _____Brookline, MA _____

Home Phone Number:_____ Email Address: _____

Vehicle Registration Number: _____ Disability Placard Number: _____

Along with the Physician's Statement and a copy of the complete Disability Placard issued by the Registry of Motor Vehicles for the Commonwealth of Massachusetts, the applicant must provide a written statement explaining why the available off-street parking space and/or current available curbside parking is inadequate to meet their needs. (Provide here or attach separate statement):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I have read the Town of Brookline policy for establishing designated curbside disabled parking spaces on public streets, and I understand the conditions required for a designated disability parking space. I also understand that the installation of a space on the public way requires a minimum 4 vote majority of the Transportation Board of the Town of Brookline. I further certify that the information provided is correct and give permission for the DPW – Transportation Division to obtain all information necessary to verify my need for this designated curbside disabled parking space.

Signature: _____ Date: _____

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