THE APPLICANT ACKNOWLEDGES THAT HE/SHE IS AWARE THAT THE TEMPORARY HANDICAP PARKING PERMIT THAT WILL BE ISSUED WILL BE ONLY FOR A SPECIFIC PERIOD OF TIME AND FURTHER ACKNOWLEDGES THAT THIS PERMIT IS ONLY WHILE THEY ARE IN THE VEHICLE.

ANY MISUSE OF THIS PERMIT WILL BE REPORTED IMMEDIATELY TO THE MEDICAL AFFAIRS BRANCH OF THE REGISTRY OF MOTOR VEHICLES AND THE COMMISSION WILL SEEK THE IMMEDIATE RETURN OF THE TEMPORARY PARKING PERMIT. IT IS UNDERSTOOD THAT THIS PERMIT WILL BE RETURNED TO WALTHAM’S H.S.C. WHEN THE EXPIRATION PERIOD IS OVER. IF THERE IS ANY LOSS OF THIS PERMIT IT IS TO BE REPORTED TO THIS OFFICE AT ONCE.

THE APPLICANT FURTHER UNDERSTANDS THAT THIS PERMIT IS ONLY VALID IN THE CITY OF WALTHAM. THIS PERMIT WILL NOT BE RECOGNIZED BY ANY OTHER CITY OR TOWN.

SIGNATURE OF APPLICANT: ______________________________________

DATE: _______________________

APPLICATION APPROVED BY: ______________________________________

DATE: _______________________

VALID UNTIL: _________________

** ONE PICTURE REQUIRED WITH APPLICATION (PROFESSIONAL PICTURE NOT REQUIRED)

MAIL BACK TO HANDICAP COMMISSION AT

WALTHAM CITY HALL - 610 MAIN STREET - WALTHAM, MA 02452
INSTRUCTIONS: An applicant for a temporary handicap parking permit must complete Part A of this form and provide medical documentation regarding the temporary handicap. The applicant's physician must either 1) Complete and sign Part B (Back page) or 2) Provide a written diagnosis, including the nature and severity of the temporary handicapping condition, and a written prognosis as to its expected duration, (either one, two or three months). If the applicant has applied for, but not received handicap plates or placard from the Registry of Motor Vehicles, a copy of the physician's questionnaire will fulfill the requirement for medical approval.

In order to qualify for a temporary handicap parking permit, one must meet eligibility requirements comparable to the Registry's requirements for a handicap parking plate or placard. These requirements include the following disabling conditions: loss or use of one or more limbs; vision impairment; knee or ankle dysfunction; or respiratory, heart or circulatory disorder. However, the disability must be expected to be temporary, rather than permanent. An exception to this requirement will be made for an individual who has applied for, but has not received a handicap plate or placard from the Registry, and for someone who has a handicap license plate, but whose vehicle is inoperative for a prolonged period of time.

This temporary parking permit will only be for the use of the person so designated on the permit. This permit can be used only while the designated person is in or using the vehicle. If there is any misuse of this Handicap Parking Permit, this permit will be immediately revoked. This permit will only be valid in the City of Waltham and must also be returned to a designated location upon expiration

PART A

1. NAME: ______________________________________________________________
2. ADDRESS: _____________________________________________________________WALTHAM, MASSACHUSETTS
3. TELEPHONE: ___________ AGE: ___________
4. DRIVER’S LICENSE: _______________ NON-DRIVER: __________
5. VEHICLE REGISTRATION NUMBER: ______________________________________

SIGNATURE OF APPLICANT __________________________________________________

WALTHAM CITY HALL - 610 MAIN STREET - WALTHAM, MA 02452
PART B

1. ATTENDING PHYSICIAN’S NAME: ________________________________________

2. MEDICAL SPECIALTY: _________________________________________________

3. ADDRESS: ___________________________________________________________
   (STREET)                                        (CITY/TOWN)                                               (ZIP)

4. TELEPHONE: _______________________LAST EXAM DATE: __________________

5. NATURE OF HANDICAP: ________________________________________________
   ___________________________________________________________________

6. EXPECTED DURATION:  1 MONTH ____  2 MONTHS ____  3 MONTHS ____

7. PLEASE NOTE WHICH, IF ANY, OF THE FOLLOWING HANDICAPS IS ATTRIBUTABLE
   TO THE APPLICANT
   a. Loss of use of one or more limbs ______
   b. Vision Impairment ______
   c. Knee or ankle dysfunction ______
   d. Respiratory, heart, or circulatory disorder ______

8. PRESCRIBED AMBULATORY AID(S) USED: YES ______ NO ______
   IF YES PLEASE DESCRIBE _____________________________________________

9. ATTENDING PHYSICIAN SIGNATURE: _____________________________________

REGISTRATION NUMBER _________________________
DATE: _______________ APPLICANT’S NEXT APPOINTMENT ____________________

IF YOU WISH TO PROVIDE ADDITIONAL MEDICAL INFORMATION OR CLARIFICATION
 THAT WOULD INFLUENCE THE APPLICANT’S ELIGIBILITY FOR A TEMPORARY HANDI-
 CAP PARKING PERMIT, PLEASE SUBMIT AN ADDENDUM ON A SEPARATE SHEET.