

CITY OF BLUE ISLAND
APPLICATION FOR RESIDENTIAL
HANDICAP PARKING SPACE

DEFINITION: "PERSONS WITH DISABILITIES" (625 ILCS 5/1-159.1)

A natural person, who, as determined by a licensed physician: (1) cannot walk 200 feet without stopping to rest; (2) cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device; (3) is restricted by lung disease to such an extent that his or her forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 mm/hg on room air at rest; (4) uses portable oxygen; (5) has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV, according to the standards set by the American Heart Association; or (6) is severely limited in the person's ability to walk due to an arthritic, neurological, or orthopedic condition.

PLEASE FILL IN:

LOCATION FOR HANDICAP PARKING SIGN

NAME: _____

ADDRESS: _____

PHONE: _____

SIGNATURE _____

(OVER)

DO YOU HAVE A GARAGE?

YES OR NO

DO YOU HAVE A DRIVEWAY?

YES OR NO

(Please fill in the disabled person's name, describe the condition, and indicate the impairments below.)

Person with Disabilities

Name: _____

Condition: _____

- _____ Cannot walk 200 feet without stopping to rest.
- _____ Cannot walk without the assistance of another person, prosthetic device, wheelchair, or other assistive device.
- _____ Is restricted by lung disease to such a degree that the person's forced (respiratory) expiratory volume (FEV) in one second, when measured by spirometry, is less than one liter.
- _____ Uses portable oxygen.
- _____ Has a Class III or Class IV cardiac condition according to standards set by the American Heart Association.
- _____ Is severely limited in the person's ability to walk due to an arthritic, neurological, or orthopedic condition.

LENGTH OF DISABILITY: check one

_____ Disability is permanent

_____ Disability is temporary - state duration (maximum 6 months) _____

I hereby certify that the physical condition of the person with disabilities listed herewith constitutes him/her as a person with disabilities as described under 625 ILCS 5/1-159.1.

Physician's Signature

Physician's license number

PLEASE PRINT OR TYPE BELOW:

Physician's Name: _____ Phone: _____

Address: _____

City: _____ Zip: _____