

**CITY OF TRENTON**  
**HANDICAP REVIEW COMMITTEE APPLICATION FOR ON-STREET**  
**HANDICAPPED PARKING**

**GUIDELINES FOR HANDICAPPED PARKING**

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Before you fill out the attached application, please make sure that none of the following apply to you or the front of your property:

- I. State of New Jersey parking prohibitions:
  - a.) Within 35 feet of sideline of a street
  - b.) Within 25 feet of a crosswalk
  - c.) Within an intersection
  - d.) Within 10 feet of a fire hydrant
  - e.) Within 50 feet of a stop sign
- II. Areas listed in the “Revised” General Ordinance of the City of Trenton and posted on the street. The area will be marked as follows:
  - a.) No stopping or standing
  - b.) No parking anytime
  - c.) Bus stop
  - d.) Loading Zone
  - e.) Any area marked for time restricted parking
- III. Driveways (off-street parking). It is the City of Trenton’s policy not to grant a handicapped parking space to those who possess off-street parking.

Should any of the above-mentioned apply to you; the City of Trenton will not be able to issue a handicapped parking space.

Also, please note that the State of New Jersey requires that in order to establish a handicapped parking space, it must be at least 22 feet in length. If your property does not have the necessary frontage, you are required to advise the adjoining property owner of the signs being placed on his/her property. The consent form is attached.

Please fill out the application as complete as possible. All of the information obtained will be used in making the final decision of providing the handicapped parking space. Once the application has been received by the Bureau of Traffic and Transportation you will then be scheduled to appear before the Handicapped Parking Review Committee. This process may take two to three months due to the number of applications received by our Bureau. (Please be patient) If you have any questions please feel free to contact 609-989-3612.

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The applicant must be handicapped in such a manner that he or she has been prescribed a mobility aiding device. This device can include a cane, walker, wheelchair, crutches, and/or artificial limb.

1. A professional medical doctor **must** certify the condition of the applicant using this applicant form.

A copy of the following **must** be submitted and the address **shall** match the requested parking space:

- a) Handicapped Person Identification Card  
(Issued by the State of New Jersey, Division of Motor Vehicle,  
Telephone No. 609-292-6500)
- b) N.J.D.M.V. Driver's license
- c) N.J.D.M.V. Vehicle Registration

2. A description of vehicle trips made by you or designated driver during an average week shall be submitted using attached form.
3. The handicapped parking space may be in front of one or two houses. Affected property owners should give their permission using attached form.
4. The applicants **must attend** a scheduled meeting of the City's Handicapped Review Committee.

**OFFICE USE  
ONLY**

**Application Out:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Application  
Return:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Approved:**

\_\_\_\_

**Denied:**

\_\_\_\_

**Installation  
Date:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Removal Date:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Applicant's Name:** \_\_\_\_\_

**Applicant's Address:** \_\_\_\_\_  
(Including Zip Code)

**Applicant's Telephone Number:** \_\_\_\_\_

**Driver's Name:** \_\_\_\_\_

**Driver's Address:** \_\_\_\_\_  
(Including Zip Code)

**Driver's Telephone Number:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

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Re: \_\_\_\_\_

Dear Doctor:

By virtue of the numerous applications for curb-side handicapped parking privileges and our very limited facilities in certain neighborhoods, it is necessary for the City of Trenton to review all applications initially and periodically thereafter to determine whether a reserved parking space is justified.

To this end, we are obligated to request that your initial certification of need on behalf of \_\_\_\_\_ be elaborated. The applicant must be non-ambulatory and use a device such as a wheelchair or crutches prescribed by a physician for a permanent handicap condition. We will also require that your certification be renewed from time to time and/or that you be willing to discuss the matter with our confirming physician.

The applicant has authorized you to provide the following information in clarification of your opinion.

All responses are intended to relate an opinion based upon reasonable medical probability.

**I CERTIFY THE ATTACHED INFORMATION AND OPINIONS TO BE TRUE.**

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PHYSICIAN'S SIGNATURE

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DATE

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PHYSICIAN'S NAME

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M.D. OR D.O. LIC. NO.

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PHYSICIAN'S ADDRESS

**I HEREBY AUTHORIZE MY PHYSICIAN OR HOSPITAL TO PROVIDE THE INFORMATION REQUESTED ON THIS FORM AND TO DISCUSS MY MEDICAL CONDITION WITH THE REPRESENTATIVES OF THE CITY OF TRENTON INCLUDING PHYSICIANS.**

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APPLICANT'S SIGNATURE

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DATE

*(The Doctor must complete this form)*

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**HANDICAP PERMIT MEDICAL FORM**

- PLEASE HAVE YOUR PRIMARY CARE PHYSICIAN COMPLETE THIS MEDICAL FORM. If you are only under the care of a Specialist, he or she should include any and all diagnosis.
- Physician Please Note: Handicapped Parking spaces are granted on a case by case basis. Your documentation will assist the Board in making a decision on whether to grant your patient a reserved space. (PLEASE EXPLAIN IN DETAIL)
  1. Please include all medical problems and state how they may impact on the need for a reserved parking space.

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2. What assistive devices does the patient use, if any? (i.e.: Cane, Walker, Etc.)

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3. What are the patient's physical limitations, if any? (i.e.: Walking distances)

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4. What is the prognosis regarding the patient's condition?

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*(The Doctor must complete this form)*

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Please provide information concerning your trip frequency. Include how many times a day, week, or month you make the following trips:

**CHURCH**

\_\_\_\_\_ time(s) per:      \_\_\_\_day      \_\_\_\_week      \_\_\_\_month      Time: \_\_\_\_\_

**DOCTOR'S**

\_\_\_\_\_ time(s) per:      \_\_\_\_day      \_\_\_\_week      \_\_\_\_month      Time: \_\_\_\_\_

**PHYSICAL THERAPY**

\_\_\_\_\_ time(s) per:      \_\_\_\_day      \_\_\_\_week      \_\_\_\_month      Time: \_\_\_\_\_

**RECREATION** (dining, visiting relatives, etc.)

\_\_\_\_\_ time(s) per:      \_\_\_\_day      \_\_\_\_week      \_\_\_\_month      Time: \_\_\_\_\_

**SHOPPING**

\_\_\_\_\_ time(s) per:      \_\_\_\_day      \_\_\_\_week      \_\_\_\_month      Time: \_\_\_\_\_

**WORK**

\_\_\_\_\_ time(s) per:      \_\_\_\_day      \_\_\_\_week      \_\_\_\_month      Time: \_\_\_\_\_

Please give an approximate time frame in which most of your daily trips are made (i.e.: 9:00am-5:00pm). \_\_\_\_\_

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**NEIGHBOR & OWNER OF PROPERTY CONSENT FORM**

Date \_\_\_\_\_

I understand that a handicap parking space has been requested in front of

\_\_\_\_\_ by: \_\_\_\_\_  
(ADDRESS) (APPLICANT)  
\_\_\_\_\_

Further, I understand that because of parking restrictions and/or insufficient property frontage, this space would have to extend across part or all of the front or side-curb line of my property. I also understand that should I park in the space, I could be subjected to a penalty of \$250.00 and/or up to 90 days community service.

**NEIGHBOR OF PROPERTY CONSENT FORM**

This is to advise that I (check one) do  do not  give permission for this installation.

Please Print Name: \_\_\_\_\_

Please Sign: \_\_\_\_\_

Property address: \_\_\_\_\_

Home address (if different): \_\_\_\_\_

Phone number: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

*\*You will be contacted by phone or mail to verify the signature and permission for this installation\**

**IF YOU DO NOT OWN THE PROPERTY WHERE YOU ARE REQUESTING THE**  
**PARKING SPACE THEN THE OWNER MUST SIGN BELOW**

Name of Property Owner: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Home Address: \_\_\_\_\_