



TOWN OF NANTUCKET
**COMMISSION ON
DISABILITY**

TOWN & COUNTY BUILDING
16 BROAD STREET
NANTUCKET, MA 02554

(508) 228-8085 (Voice Only)



APPLICATION FOR NANTUCKET DISABLED PARKING PLACARD

*THIS SIDE OF THE APPLICATION MUST BE COMPLETED BY THE APPLICANT OR HIS/HER
DESIGNEE*

Last Name: _____ First Name: _____ MI: _____

On Island Address: _____

Mailing Address: _____

Off Island Address: _____ City _____ State _____ Zip _____

Date of Birth: _____ Telephone: _____

E-mail Address: _____

(There are times that we receive information that may be useful to you. We will not share your e-mail address with anyone.)

I am applying to the Nantucket Commission on Disability for a Nantucket Parking Permit for the Disabled to be used only on the Island of Nantucket, MA.

I understand that the laws and regulations of the Commonwealth of Massachusetts and the Town of Nantucket shall govern the use of this permit. Failure to abide by these regulations shall be deemed just cause for revocation and surrender of the permit to the Chief of Police of Nantucket.

As part of this application, I am submitting the Physician's Statement on the reverse side for use by the Nantucket Commission on Disability in determining my eligibility for a permit. A permit will be issued only when a disability affects ambulatory mobility. **Use of this permit by anyone other than the applicant is cause for immediate revocation.**

Signature of Applicant (or Designee)

Date

Our Commission will review this application at our next monthly meeting. You have the right to attend our meeting while the Commission members discuss your permit application. However, the Commission will review your application even if you decide not to attend. We will contact you and let you know when your permit will be reviewed.

*Should you need a **temporary permit immediately**, the Chief of Police may issue you a 6-week permit. A Physician's Statement is required when applying to the Chief of Police.*

PHYSICIAN'S STATEMENT – PARKING PERMIT FOR DISABLED

Dear Healthcare Provider:

This is an application to allow your patient to display a local disabled placard. This will allow your patient to park in designated “disabled” parking spaces designed to increase access for people with impaired mobility. The medical criteria you fill out below will enable the Commission on Disability to determine patient eligibility for the privilege of accessing select parking spaces.

Please be accurate and detailed as possible to ensure that the Commission on Disability may make a fair evaluation of your patient’s application.

The disability is **Permanent** **Temporary**

If temporary: Anticipated length of disability _____

Please state clinical diagnosis and exact nature of impairment. **(Mandatory answer)**

How does the disability affect patient’s mobility? **(Mandatory answer)**

Ambulatory aids used: _____

Please note which of the following disabilities is attributable to the applicant.

<input type="checkbox"/>	Loss of, or loss of use of one or both feet	
<input type="checkbox"/>	Replacement of Joint in lower extremity	___ Hip ___ Knee ___ Ankle
<input type="checkbox"/>	Complete ankylosis of major joint or lower extremity	___ Hip ___ Knee ___ Ankle
<input type="checkbox"/>	Paralysis of lower extremity	___ Hip ___ Knee ___ Ankle
<input type="checkbox"/>	Arthritis of Joint in lower extremity	___ Hip ___ Knee ___ Ankle
<input type="checkbox"/>	Chronic Lung Disease	
<input type="checkbox"/>	Chronic Heart Disease	
<input type="checkbox"/>	Other (Describe)	

Name of Physician: (Please Print) _____

Mailing Address: _____

Office Phone: _____ **Signature:** _____

For Commission Use Only

Date Received _____	COD Signatures _____
Permit Number _____	_____
Permit Expires _____	_____
Permit Renewal _____	