Policy for Designated Disabled On-Street Parking Spaces in Residential Neighbourhoods

Disabled Parking cannot be established in an area already restricted as **NO PARKING** or **NO STOPPING.**

Disabled Parking is not designated when off-street parking (driveway, garage or parking lot) is available and accessible.

Disabled Parking signs do not exempt a vehicle from other parking regulations.

Disabled Parking Spaces may be used by **anyone** with a valid SPARC permit.

The City reserves the right to reject requests for Disabled Parking Spaces that will be used infrequently or will cause a hazard to the public.

Disabled Parking Spaces are subject to review every three (3) years, or when the City of New Westminster deems appropriate. Should the need no longer exist, the sign designating the space will be removed.

When the Disabled Parking Space is no longer needed due to the applicant's change in residence or change in eligibility status, the applicant or a member of his/her household shall notify the City of New Westminster's Engineering Services within thirty (30) days of this change.

To apply for a Disabled On-Street Parking Space near your residence, please submit the following documentation to the City of New Westminster's Engineering Services:

1. The completed Residential Disabled Parking application.
2. A written statement from the property owner/strata council that no off-street parking space (driveway, garage or lot) is available, or why the available off-street parking is inadequate.
3. The completed attending physician's form documenting the need for a Residential Disabled Parking Space.
4. A photocopy of the SPARC permit documentation

Doc# 659095

Contact Us

Engineering

604 527 4592 | engpost@newwestcity.ca

Residential Disabled Parking Space Application Form

Please provide the following information:

Name of Applicant:_____

Address of Applicant: _____

Phone Number: _____

Applicant's Driver's License: _____

Vehicle's License Plate Number: _____

Disability Permit Number:_____

You must provide a written statement from the owner of the property or strata council that you either have no off-street parking where you live, or why the available off-street parking is inadequate or unavailable:

_____

_____

_____

_____

_____

I have read the City of New Westminster's policy for establishing Disabled Parking Spaces in residential areas and I understand the conditions required for a designated Disabled Parking Space. I also understand that my application is subject to the review of the Director of Engineering.

I certify that the information provided is correct and may be subject to verification. I also give permission for the City of New Westminster's Engineering Services to obtain all information necessary to verify my need for this designated parking space.

Date: _____

Signature of Applicant: _____ **Name Printed:** _____

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New Westminster

Residential Disabled Parking Space Physician Form

Please provide the following information:

Name of Applicant:_____

Address of Applicant: _____

To Physician: Approval for a Residential Disabled Parking Space is based in part on information provided by you. If this applicant (your patient) has a "hidden" disability (ie: one that is not visibly obvious), it will be incumbent upon 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. Residential Disabled Parking Spaces are available to those with substantial functional limitations that affect mobility for more than six months.

Please answer the following:

Does the applicant have long term mobility impairment? [ ] No [ ] Yes

If YES, please specify:
_____
_____
_____
_____

Are mobility aids prescribed? [ ] No [ ] Yes
If 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 Residential Disabled Parking Space desirable:
_____

_____

Name of Physician:_____
(Please include a business card or office letterhead with this application)

Address or Telephone Number of Physician: _____

_____

I hereby certify that the above information is correct.

Signature of Physician: _____ **Date:** _____

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