



SFMTA

MEDICAL AFFIDAVIT

I, _____, am the **ATTENDING PHYSICIAN**
 for _____, who resides at _____
 _____. This address is located within the boundaries of
 Residential Permit Parking Area _____. He/She requires health care during the time each day
 that the Residential Parking ordinance is in effect.

I declare under penalty or perjury that the foregoing is true and correct.

 Physician's Signature

 Date

 Physician's License Number

I am a **HEALTH CARE PROFESSIONAL** caring for _____ who resides
 at _____.

I hereby apply for a Residential Parking Permit for AREA _____.

**I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND
 CORRECT**

 Health Care Attendant's Name (Printed)

 Signature

 Date

Transferrable Permit (Shared among multiple caretakers): YES NO

*If yes then do not fill out the vehicle information below

 Year/Make of Vehicle

 License Plate #

SFMTA AGENCY USE ONLY: PERMIT # _____