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 #_____