

Residential Preferential Parking (RPP) Program

In-Home Care Permit Medical Affidavit Form

l,	, am the ATT	, am the ATTENDING PHYSICIAN for	
	, who resides at		
	, located within the boundaries	s of RPP Area	
He/she/they requires	s health care during the time of each da	ay that the Residential	
Parking Ordinance is	s in effect.		
I declare under pena	alty of perjury that the foregoing statem	ent is true and correct.	
ATTENDING PHYSI	CIAN'S SIGNATURE DAT	 E	
Attending Physician'	s License #		
I am a healthcare professional for, who			
	or RPP Area	nereby apply for an RPP in-	
	ler perjury that the foregoing statement	t is true and correct.	
Up to three permits r	may be purchased:		
NAME	SIGNATURE	DATE	
NAME	SIGNATURE	DATE	
NAME	 SIGNATURE	 DATE	