

**2016 SOUTH EUCLID DISABILITY PASS  
PHOTO ID AND CURRENT PROOF OF RESIDENCY  
REQUIRED TO COMPLETE APPLICATION PROCESS**

PLEASE PRINT  
LAST NAME

FIRST NAME

SCHOOL CHILD  
ATTENDS

AGE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE(\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_) \_\_\_\_\_ EMERGENCY PHONE(\_\_\_\_) \_\_\_\_\_

**PLEASE READ BEFORE SIGNING APPLICATION**

I have received swim pass(es) and understand and acknowledge that although every reasonable precaution has been taken to insure the safety of all those who use the pool and/or the water slide, certain risks of injury are inherent in their use, and injury may result in spite of said precautions.

I, therefore, acknowledge those risks and release the City of South Euclid and all its employees, agents, volunteers and workers from any and all liability for any claims of injury of any kind resulting from the use of said facilities. I further understand that the receipt given to me today must be taken to Bexley pool in exchange for a photo I.D. pass and I must present the photo I.D. pass upon entry to the pool and/or Splash Park.

SIGNED \_\_\_\_\_ DATED \_\_\_\_\_

Proof of Residency : DL \_\_\_\_\_ UTILITY BILL \_\_\_\_\_

**DOCTORS USE ONLY: (valid for 2016 Season only)**

Name of applicant with disability: \_\_\_\_\_

Date of most recent visit: \_\_\_\_\_

*In your professional opinion, does the above patient qualify for a 2016 Disability Pass under the Federal Americans with Disabilities Act of 1990?*

\_\_\_\_\_  
\_\_\_\_\_

Doctor's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's name: \_\_\_\_\_  
(please print)

Office phone number: \_\_\_\_\_

\*\*\*\* IN ORDER TO AUTHENTICATE THIS APPLICATION, PLEASE STAMP WITH YOUR OFFICIAL OFFICE STAMP\*\*\*\*