

South Miami Hospital

Application for Miami Dade County Baby Stroller Parking Permits

APPLICANT NAME:
(First, M.I., Last)

Parent

Guardian

GOVERNMENT ID:
(Driver's License, State ID)

CHILD's NAME:

CHILD's BIRTH DATE:
(mm/dd/yyyy)

FORM OF PAYMENT:

Cash

Check

Money Order

Credit Card

AFFIDAVIT:

I acknowledge that the information in this application is true and correct. Providing false or misleading information could result in revocation of the Baby Stroller Permit eligibility as well as other penalties or remedies provided under the statutes of the laws of the State of Florida.

SIGNATURE:

DATE:

Permit number #1:

One Permit

Permit number #2:

2nd Permit (Optional):

Permit(s) Expires:

Total Amount Due:

PROCESSED BY:

Hospital

Miami Dade County

Print your name

Print your name