

CITY OF CROSSVILLE TEMPORARY
STREET CLOSURE PERMIT APPLICATION

FOR DEPARTMENT USE ONLY:

DATE RECEIVED: ___ / ___ / 20___

DATE OF APPROVAL: ___ / ___ / 20___

EVENT SPONSOR:

NAME: _____ PHONE NUMBER: _____ - _____ - _____

EMAIL: _____

DATE OF STREET CLOSURE: ___ / ___ / 20___ TIME: _____

DESCRIPTION OF REASON FOR REQUEST: _____

LOCATION, ROUTE, STREETS AND/OR INTERSECTIONS (PLEASE ATTACH A MAP THAT IS CLEARLY
MARKED): _____

DESCRIPTION OF ANY RECORDING EQUIPMENT, SOUND AMPLIFICATION EQUIPMENT, OR OTHER
DEVICES USED IN CONNECTION WITH THIS EVENT: _____

APPLICANT SIGNATURE

___ / ___ / 20___

DATE

CITY CLERK SIGNATURE

___ / ___ / 20___

DATE