



REQUEST FOR TEMPORARY STREET CLOSURE

Contact Name: _____

Address: _____

Phone Number: _____

Email Address: _____

Organization Name: _____

Event: _____

Date of Event: _____

Time You Are Requesting Closure: _____

Location You Are Requesting Closed: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Approved _____ Not Approved _____ Reason _____

_____ Date: _____

City of Coshocton

Upon approval this application becomes the formal Street Closure Permit