



New York State Department of Motor Vehicles
**APPLICATION FOR A PARKING PERMIT OR LICENSE PLATES,
 FOR PERSONS WITH SEVERE DISABILITIES**



Take this completed application to the **issuing agent in the area where you live**. Also, if you have a **NYS driver license or an ID card issued by NYS DMV**, bring it with you when you apply for the permit.

Part 1 INFORMATION ABOUT PERSON WITH DISABILITY —(Please print, and sign by the arrow.)

| | | | |
|--|---|---|----------------------|
| Last Name | First | M.I. | Telephone No. () |
| Address: No. and Street | | Apt. No. | City State Zip Code |
| Date of Birth | <input type="checkbox"/> Male <input type="checkbox"/> Female | I am applying for <input type="checkbox"/> License Plates (Apply to DMV.) <input type="checkbox"/> Parking Permit (Apply to local issuing agent.) | |
| Do you have license plates for persons with disabilities? <input type="checkbox"/> Yes - My license plate number is: _____ <input type="checkbox"/> No | | | |
| See Note on Page 2 | | | |
| (Signature of Person with Disability or Signature of Parent or Guardian) — If signed by a parent or guardian, please state your relationship to the person with the disability after your signature. | | | (Date) |

Part 2 MEDICAL CERTIFICATION—This section must be completed only by a Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM) or a Nurse Practitioner (NP). Please certify whether the patient's disability is permanent or temporary.

Check the box(es) that describe the disability, and fill in the diagnosis:

TEMPORARY DISABILITY: A person with a temporary disability is any person who is temporarily **unable to ambulate without the aid of an assisting device**, such as a brace, cane, crutch, prosthetic device, another person, wheelchair, walker or other assistive device. (Temporary permits are issued for periods of six months or less.)

Expected Recovery Date _____

Diagnosis: _____

What assistive device is needed? _____

PERMANENT DISABILITY: A "severely disabled" person is any person with one or more of the PERMANENT impairments, disabilities or conditions listed below, which limit mobility.

Diagnosis: _____ Please check the conditions that apply:

- Uses portable oxygen Legally blind Limited or no use of one or both legs Unable to walk 200 ft. without stopping
- Neuromuscular dysfunction that severely limits mobility Class III or IV cardiac condition. (American Heart Assoc. standards)
- Severely limited in ability to walk due to an arthritic, neurological or orthopedic condition
- Restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg of room air at rest
- Has a physical or mental impairment or condition not listed above which constitutes an equal degree of disability, and which imposes unusual hardship in the use of public transportation and prevents the person from getting around without great difficulty. **EXPLAIN HOW THIS DISABILITY LIMITS FUNCTIONAL MOBILITY.**

| | |
|----------------------|--------------------------|
| MD/DO/DPM/NP Name | Professional License No. |
| MD/DO/DPM/NP Address | Telephone No. () |

See Note on Page 2

(MD/DO/DPM/NP Signature)

(Date)

Part 3 FILE INFORMATION (For Issuing Agent Use Only)

| | | |
|--|--|---------------------|
| <input type="checkbox"/> Blue <input type="checkbox"/> Red Parking Permit No. _____ | Date Issued: _____ | Date Expires: _____ |
| <input type="checkbox"/> First <input type="checkbox"/> Second | 9-digit number from NYS Driver License/ID Card _____ | |
| <input type="checkbox"/> Denied <input type="checkbox"/> Revoked Reason: _____ | | |
| | | (Date) |
| (Issuing Agent) | | (Locality) |