



New York State Department of Motor Vehicles
**APPLICATION FOR LICENSE PLATES OR PARKING PERMITS
 FOR PEOPLE WITH SEVERE DISABILITIES**



Part I CUSTOMER INFORMATION — (Please print and sign where indicated.)

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 <input type="checkbox"/> Parking Permit <input type="checkbox"/> Second Permit	
I <input type="checkbox"/> have <input type="checkbox"/> do not have license plates for people with disabilities. If "Yes", my license plate number is: _____			
(Applicant's Signature or Signature of Parent or Guardian) — <i>If signed by parent or guardian, please indicate your relationship to the applicant after your signature.</i>			(Date)

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

Check the box(es) that describe the disability:

TEMPORARY DISABILITY: A temporarily disabled person is any person who is 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 ____/____/____.

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. 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. Describe the specific impairment, disability or condition and **explain** how it limits mobility.

Physician/Podiatrist Name	Professional License No.
Physician/Podiatrist Address	Telephone No. ()

 (Physician/Podiatrist Signature) (Date)

I certify that the information above is true and that I have read and understand the conditions of this application and will comply with them. IMPORTANT: False statements are punishable under Section 210.45 of the Penal Law.

Part III. FILE INFORMATION (For Issuing Agent Use Only): **Parking Permit No.** _____

PERMIT: First Second Permanent Temporary Issuance Date: _____ Expiration Date: _____

Denied Revoked Revocation Date: _____

Reason: _____

 (Issuing Agent) (Locality)