**APPLICATION FOR NEW YORK STATE (NYS) PARKING PERMIT FOR PERSONS WITH SEVERE DISABILITIES**

*(You are eligible for this permit **only** if you are a **severely disabled person** as defined on the reverse of this form.)*

***Please return this application to:***

**ANDREW P. RAIA, TOWN CLERK**
**100 MAIN STREET**
**HUNTINGTON, NY 11743-6991**
**(631) 351-3206; Fax# (631) 351-3205**

**FOR OFFICE USE ONLY**

| (☐T) Permit # | Date | Clerk |
|---|---|---|
| 2nd Permit # | Date | Clerk |
| Rplc Permit# | Date | Clerk |

**PART I** **(TO BE COMPLETED BY THE APPLICANT, GUARDIAN OR THE PARENT ON BEHALF OF THEIR CHILD.)**

**NAME OF APPLICANT:**_____
**(Please Print)** LAST FIRST MIDDLE

**DATE OF BIRTH: Month_____Day_____Year_____** ☐**Male** ☐**Female**

**RESIDENCE:**_____
STREET CITY STATE & ZIP

**MAILING ADDRESS:** _____
(If different from Residence)

**TELEPHONE**: (**Daytime**) **(_____)**_____ (**Evening**) **(_____)**_____

**E-MAIL ADDRESS:** _____

**DO YOU HAVE LICENSE *PLATES* FOR PERSONS WITH DISABILITIES?** ☐ **Yes** ☐ **No**
**If you answered "yes" please attach a photocopy of your vehicle's New York State registration.**

***NYS DRIVER LICENSE ID#:_____-_____-_____ EXPIRES ON:_____**

***OR* NYS NON-DRIVER ID#:_____-_____-_____ EXPIRES ON:_____**

**A PHOTOCOPY OF ABOVE ID MUST BE PROVIDED. CHECK THIS BOX ☐ IF YOU *DO NOT* HAVE EITHER ONE OF THE ABOVE IDENTIFICATION CARDS.**

**I UNDERSTAND THAT ACCORDING TO NEW YORK STATE LAW, THIS PERMIT IS NOT TRANSFERABLE AND IS INTENDED FOR ME TO USE ONLY WHEN I AM RIDING IN A VEHICLE. ANY MISUSE OF THIS PERMIT MAY BE GROUNDS FOR REVOCATION AND FINE.**

**I CERTIFY THAT THE INFORMATION ABOVE IS TRUE AND CORRECT AND THAT I WILL COMPLY WITH "THE CONDITIONS" OUTLINED ON THE REVERSE OF THIS APPLICATION.**

Do you wish to be on a **confidential** Office of Handicap Services mailing list to receive informative newsletters and/or notices?

☐ **YES, include** my name/address/e-mail address
☐ **NO, do not include**

_____
**SIGNATURE OF APPLICANT**

_____
**SIGNATURE OF PARENT/GUARDIAN**

Relationship to Applicant: _____

**ATTENTION:**
**FALSE STATEMENTS ARE PUNISHABLE UNDER §210.45 OF THE PENAL LAW & §1203-a(4) NYS VEHICLE & TRAFFIC LAW**

_____
**DATE**

***IMPORTANT NOTICE:** **NYSDMV requirement to enable enhanced law enforcement of violations.**

**(Rev06/15)**

**NOTE: A PHYSICAL EXAMINATION IS NOT REQUIRED. MEDICAL CERTIFIER MUST COMPLETE PART II, SECTION A OR B, OF THIS APPLICATION OR SUBMIT A LETTER DESCRIBING IN FULL THE NEED FOR THE PERMIT.**

**PART II MEDICAL CERTIFICATION (**Medical Doctor, Doctor of Osteopathy, Podiatrist (for disabilities related to the foot), Nurse Practitioner or Physician's Assistant, Optometrist (for blindness)**

**NAME OF MEDICAL CERTIFIER: (Please Print)_____**

**SPECIALTY:_____ PROFESSIONAL LICENSE #:_____**

**SIGNATURE: _____DATE:_____**

**ADDRESS:_____ TELEPHONE #:_____**

**NAME OF PATIENT(APPLICANT): (Please Print)_____**

****MEDICAL CERTIFIER MUST COMPLETE *EITHER* SECTION A, *OR* B, AS APPLICABLE****

**PERMANENT PERMITS are issued to qualified severely disabled persons only, defined in VTL§404-a(4) and Fed.Reg.23 CFR 1235.2 as having one or more of the following impairments that are Permanent in nature:**

1. **uses portable oxygen;**
2. **blindness;**
3. **limited or no use of one or both legs;**
4. **unable to walk 200 ft. without stopping;**
5. **a neuromuscular dysfunction which severely limits mobility;**
6. **class III or IV cardiac condition (American Heart Assoc. Standards);**
7. **severely limited in ability to walk due to an arthritic, neurological, or orthopedic condition**
8. **restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry is less than one litre, or the arterial oxygen tension is less than sixty mm/hg of room air at rest.**
9. **another physical or mental condition not included above, which constitutes an equal degree of disability. The disability prevents the person from getting around without great difficulty, and is of such a nature as to impose unusual hardship in using public transportation.**

****A. MEDICAL CERTIFIER: Please briefly specify the details of the severely disabling condition that qualifies the applicant to be eligible for a NYS PERMANENT Disability Permit:**

**(Please Print):_____**

**_____**

**TEMPORARY PERMITS may be issued to anyone who is certified by a physician/podiatrist/MD or DO as temporarily unable to walk without the help of an assisting device (VTL§1203-a(3)), these devices include wheelchairs, crutches, walkers, canes, prostheses, portable oxygen or others; and to visitors from another country who are disabled and traveling in New York State (VTL§1203-a(1)(i)).**

****B. MEDICAL CERTIFIER: Please briefly specify nature of disability that qualifies the applicant to be eligible for a NYS TEMPORARY Disability Permit:**

**(Please Print):_____**

**_____**

**Expected Recovery Date: ____/____/____ Duration of Temporary Permit (weeks/months): _____**

**Maximum period six (6) months. Renewal for additional six (6) months requires further Medical Certifier verification in writing.**

**ATTENTION MEDICAL CERTIFIERS: FALSE STATEMENTS ARE PUNISHABLE UNDER NYS PL§210.45 & VTL§1203-a(4)**

**(REV. 06/15)**