

HANDICAPPED PARKING PLACARD APPLICATION

The Department of Public Safety requires approximately 10 business days after receipt to process the application.

NOTICE: The information submitted on this form may cause a review of your ability to operate a motor vehicle as provided in 47 O.S. Section 6-119, pursuant to the standards prescribed by the driver license medical advisory committee as created in 47 O.S. 6-118.

THIS FORM MUST BE FULLY COMPLETED BY APPLICANT AND PHYSICIAN BEFORE A HANDICAP PLACARD CAN BE ISSUED.

**THERE IS A \$1.00 PROCESSING FEE FOR EACH PLACARD ISSUED. MAKE CHECK PAYABLE TO: DEPARTMENT OF PUBLIC SAFETY
PLEASE DO NOT SEND CASH.**

I hereby make application to the Oklahoma Department of Public Safety for a handicapped parking placard. I understand I must display the official placard on the rearview mirror of my vehicle. I further understand this item may only be displayed in motor vehicles either operated by me, or in which I am a passenger. I further understand that any person who knowingly makes false application for or unauthorized use of a handicapped placard is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not more than \$500.00.

PLEASE PRINT OR TYPE

APPLICANT'S (PATIENT) NAME: _____ DATE OF BIRTH: _____
(FIRST) (MIDDLE) (LAST)

MAILING ADDRESS: _____
(STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DRIVER LICENSE NUMBER: _____ PHONE: _____
(HOME)

SIGNATURE: _____

THE FOLLOWING MUST BE COMPLETED BY A PERSON LICENSED TO A PRACTICE MEDICINE, SURGERY, OSTEOPATHIC, CHIROPRACTIC OR PEDIATRIC MEDICINE, OR OPTOMETRY.

THE ABOVE NAMED APPLICANT (PATIENT):

- | | |
|---|--|
| <input type="checkbox"/> A. CANNOT WALK TWO HUNDRED (200) FEET WITHOUT STOPPING TO REST, OR | <input type="checkbox"/> B. CANNOT WALK WITHOUT THE USE OF OR ASSISTANCE FROM A BRACE, CANE, CRUTCH, ANOTHER PERSON, PROSTHETIC DEVICE, WHEELCHAIR OR OTHER ASSISTANT DEVICE, OR |
| <input type="checkbox"/> C. IS RESTRICTED TO SUCH AN EXTENT THAT THE PERSON'S FORCED (RESPIRATORY) EXPIRATORY VOLUME FOR ONE (1) SECOND, WHEN MEASURED BY SPIROMETRY, IS LESS THAN SIXTY (60) MM/HG ON ROOM AIR AT REST, OR | <input type="checkbox"/> D. MUST USE PORTABLE OXYGEN, OR |
| <input type="checkbox"/> E. HAS FUNCTIONAL LIMITATIONS WHICH ARE CLASSIFIED IN SEVERITY AS CLASS III OR CLASS IV ACCORDING TO STANDARDS SET BY THE AMERICAN HEART ASSOCIATION, OR | <input type="checkbox"/> F. IS SEVERELY LIMITED IN HIS OR HER ABILITY TO WALK DUE TO AN ARTHRITIC, NEUROLOGICAL, OR ORTHOPEDIC CONDITION, OR |
| <input type="checkbox"/> G. IS CERTIFIED LEGALLY BLIND, OR | <input type="checkbox"/> H. IS MISSING ONE OR MORE LIMBS WHICH IMPAIRS MOBILITY. |

IN YOUR PROFESSIONAL OPINION WOULD THIS CONDITION AFFECT THIS PERSON'S ABILITY TO SAFELY OPERATE A MOTOR VEHICLE UNDER NORMAL OR ADVERSE DRIVING CONDITIONS?

- NO
 YES DIAGNOSIS: _____

TYPE OF PLACARD REQUESTED: 5 YR. PLACARD
 TEMPORARY ISSUED TEMPORARY PLACARD EXPIRATION DATE: _____
 FOR UP TO 6 MONTHS

I certify that the applicant's physical disability described above is accurate and the care and treatment is within the authorized scope of my practice.

DATE: _____ PHYSICIAN'S NAME: _____ PLEASE PRINT OR TYPE PHYSICIAN'S LICENSE NO. _____

ADDRESS: _____ (STREET OR P.O. BOX) (CITY) (STATE)

PHONE: _____ PHYSICIAN'S SIGNATURE: _____

FOR DPS OFFICE ONLY

Expiration Date: _____ Date issued: _____ Placard Number: _____

Mail this completed application with one dollar check to:
Oklahoma Department of Public Safety
Driver License Services Division
P.O. Box 11415
Oklahoma City, OK 73136-0415

If you have any questions, please call (405)425-2290