

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. If your physician indicates a medical condition that may adversely affect your ability to safely operate a motor vehicle further medical information will be requested.

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 PRACTICE MEDICINE, SURGERY, OSTEOPATHIC, CHIROPRACTIC OR PODIATRIC 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 ONE (1) LITER, OR THE ARTERIAL OXYGEN TENSION 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 FOR UP TO 6 MONTHS _____ TEMPORARY PLACARD EXPIRATION DATE: _____

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

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