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):

- ☐ A. CANNOT WALK TWO HUNDRED (200) FEET WITHOUT STOPPING TO REST, OR
- ☐ 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
- ☐ 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
- ☐ G. IS CERTIFIED LEGALLY BLIND, OR
- ☐ B. CANNOT WALK WITHOUT THE USE OF OR ASSISTANCE FROM A BRACE, CANE, CRUTCH, ANOTHER PERSON, PROSTHETIC DEVICE, WHEELCHAIR OR OTHER ASSISTANT DEVICE, OR
- ☐ D. MUST USE PORTABLE OXYGEN, OR
- ☐ F. IS SEVERELY LIMITED IN HIS OR HER ABILITY TO WALK DUE TO AN ARTHRITIC, NEUROLOGICAL, OR ORTHOPEDIC CONDITION, OR
- ☐ 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: ______________________ 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