

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 \$100 PROCESSING FEE FOR EACH PLACARD ISSUED. MAKE CHECKS 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 PO BOX CITY STATE ZIP

DRIVER LICENSE NUMBER: _____ PHONE: _____
(AREA)

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 AN ASSISTANCE FROM A BRACE, CANE, CRYSTIC, ANOTHER PERSON, PROSTHETIC DEVICE, WHEELCHAIR OR OTHER ASSISTANT DEVICE, OR |
| <input type="checkbox"/> C. IS RESTRICTED TO SUCH EXTENT THAT THE PHYSICIAN FURNISHES (PROVIDES) EXTENDED CARE FOR ONE (1) YEAR, OR THE APPLICANT CANNOT TRAVEL A LINE THROUGH ANY BUILDING OR ROOM GREAT THAN 20' | <input type="checkbox"/> D. MUST USE PORTABLE TOILET OR |
| <input type="checkbox"/> E. HAS FUNCTIONAL LIMITATIONS WHICH ARE CLASSIFIED HEREIN BY CLASS A OR CLASS B 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 ANATOMIC, 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 IMPAIR MOBILITY |

IN YOUR PROFESSIONAL OPINION WOULD THE 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: _____ 3 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: _____ PLEASE PRINT OR TYPE PHYSICIAN'S LICENSE NO. _____

ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP

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 1982
Oklahoma City, OK 73101-0192

If you have any questions, please call 1-800-422-2260

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