Town of Southeast
Handicap Parking Application (Part 1)

Office use only: **Permit** # _____ **P** **T**

Part 1 – To be completed by the handicapped applicant or guardian on behalf of handicapped child.

Eligibility Requirements:

1. Resident of New York State.
2. **Severely disabled** with a qualifying **mobility impairment** (permanent or temporary).

Name _____
last first middle

Address_____

Date of Birth _____ Sex _____ Telephone # _____

I do ____ do not ____ have license plates for people with disabilities.
I yes, please supply license plate # _____

I **certify** that the information above is true and that I have read and understand the conditions of this application and will comply with them. (If signed by a parent or guardian, please indicate your relationship of the applicant, after your signature.)

_____ _____
Signature (or signature of parent or guardian) Date

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MEDICAL CERTIFICATE
(All items must be completed before application is submitted)

_____ _____
Physician/Podiatrist Name Profession License Number

_____ _____
Physician/Podiatrist Telephone Number

A "**SEVERLY DISABLED PERSON**" is any person with any one of the following **mobility** impairments, disabilities or conditions. Please check box(es) describing applicant's impairments(s)

_____ has limited or no use of one or both legs

_____ has a neuro-muscular condition that severely limits mobility

_____ has other physical or mental condition not included above, which constitutes an equal degree of disability. The disability prevents the person from getting without GREAT difficulty.

_____ is legally blind

The following explanation must be specified:
Please write LEGIBLY and specify how the applicant's disability limits or impairs his/her ability to walk. If appropriate, specify any walking aids that you have prescribed, such as cane, crutches, walker, braces, wheelchair, prosthesis, portable oxygen or other. Please explain why the applicant's impairment is permanent. Explain how the patient's MOBILITY impairment is similar to one of the other qualifying disabilities, and specify what the comparable disability is.

_____

_____

_____

_____

_____ If the applicant's impairment is temporary and he/she is unable to ambulate without the aid of an assisting device, please check and give the expected recovery date.

I HEREBY CERTIFY THE ABOVE INFORMATION

_____ _____
Physician/Podiatrist Signature Date