Department of Public Safety

Physical Disability Parking Placard Application

The Department of Public Safety requires approximately 20 business days after receipt to process the application.

Sections 1 and 2 of this form must be completed by applicant (patient) and physician before a disability placard can be issued. If you are only seeking a replacement placard which has been lost, stolen or destroyed, only Section 1 must be completed.

Type of placard requested: ☐ **New** ☐ **Renewal** ☐ **Replacement (Lost/Stolen/Destroyed)**

Number of placards requested: ☐ **1 placard** ☐ **2 placards** (Limit 1 replacement placard if lost, stolen or destroyed during the term of the original placard)

I hereby make application to the Department of Public Safety for a physical disability parking placard. I understand I must display the official placard on the rearview mirror upon parking. I understand the placard may only be displayed in motor vehicles either operated by me, or in which I am a passenger. I understand that any person who knowingly makes false application for a disability parking placard, or makes or allows unauthorized use thereof, is guilty of a misdemeanor and upon conviction shall be punished by a fine of $500.

Section 1 (Please print or type)

Applicant (patient) name: _____ Date of birth: _____
(First) (Middle) (Last)

Mailing address: _____
(Street or P.O. box) (City) (State) (Zip)

Driver License or State Identification Card Number: _____ Phone: _____
(Home)

NOTICE: I understand that by signing and submitting this form, my ability to operate a motor vehicle may be reviewed by the Department as provided in 47 O.S. § 6-119, pursuant to the standards prescribed by the Driver License Medical Advisory Committee as created in 47 O.S. § 6-118.

Signature of Applicant or Person Responsible for Applicant (required): _____

NOTICE: The Department shall only consider new or renewal applications submitted within sixty (60) days of the date of the physicians signature in Section 2.

Section 2

The following section must be completed in full by a physician licensed to practice medicine or surgery, osteopathic medicine, chiropractic, podiatric medicine, or optometry; a licensed physician assistant; or a licensed and certified advanced registered nurse practitioner.

Physician's statement concerning the above-named applicant (patient):

- ☐ **A.** Cannot walk 200 feet without stopping to rest, or
- ☐ **B.** Cannot walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistant device, **(Must circle appropriate response)**
- ☐ **C.** Is restricted to such an extent that the person's forced (respiratory) expiratory volume for one liter, or the arterial oxygen tension is less than 60MM/HG on room air at rest, or
- ☐ **D.** Must use portable oxygen, 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
- ☐ **F.** Is severely limited in his or her ability to walk due to an arthritic neurological, or orthopedic condition, or complications due to pregnancy, **(Must circle appropriate response)**
- ☐ **G.** Is certified legally blind, 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

Type of placard approved by signing physician (choose one):

☐ Temporary Placard - issued for a maximum of 6 months. Select expiration date for placard not to exceed 6 months _____

☐ 5-Year Placard

I certify that the applicant's (patient's) physical disability described above is accurate, and said diagnosis 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: _____

Physicians must indicate the type of placard and provide all information along with their signature.

FOR DPS OFFICE ONLY

Expiration date: _____ Date issued: _____ Placard number: _____

Mail this completed application to:
Department of Public Safety
Driver Compliance Div. - Disability Parking Permits
P.O. Box 11415
Oklahoma City, OK 73136-0415

If you have any questions, please consult the frequently asked questions (FAQs) found on our website at www.ok.gov/dps/ or call (405)425-2693.