United Keetoowah Band of Cherokee Indians

# Physical Disability Parking Placard 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 United Keetoowah Band of Cherokee Indians in Oklahoma Tag Office 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: _____

**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 with the use of or assistance from a brace, cane, Crutch, another person, prosthetic device, wheelchair or other Assistance device. **(Must circle appropriate response)**

_____C. Is restricted to such and 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 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/Zip)

Phone: _____ Physician's signature: _____

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