

INSTRUCTIONS FOR APPLICATION

1. MUST BE A NASSAU COUNTY RESIDENT.

You are eligible for a permit if you are a resident of Nassau County who has one or more severe disabilities that impair your mobility.

All applications must have a Nassau County street address (**No Post Office Boxes**).

2. All applications must be fully completed and properly executed.
All questions must be answered and Medical Certification **MUST** be completed by a New York State Practicing Licensed Medical Doctor. All Applications must be signed **not stamped**.

***** NO CHIROPRACTOR *****

3. All **permits are issued in the name of the person with the disability**, therefore all Information on application **must** pertain to the disabled applicant.

You do not have to be the driver . Children and non drivers can apply for a permit.
Application must be in the name of the person with the disability.

4. The Department of New York State Motor Vehicles requires the disabled person's New York State Drivers License Client ID number or on a NYS ID card to be on the permit. Enclose a copy of disabled applicants ID (not the person driving them) with this Completed application.
5. **COPIES OR FAXES** of Applications will result in immediate **denial**.
6. To expedite the issuance of your permit upon approval, please enclose a self-addressed (number 10 size) envelope.
7. Any **FALSE** statement on the application by the applicant or by the doctor will result in refusal to issue a permit.

NASSAU COUNTY OFFICE FOR THE PHYSICALLY CHALLENGED STATE HANDICAPPED PARKING PERMIT APPLICATION
60 CHARLES LINDBERGH BOULEVARD, UNIONDALE, N.Y. 11553 (516) 227-7399

PART I PERSONAL INFORMATION (To be completed by disabled person)

Name of Disabled Person _____
(please print) last first middle initial

Address _____
house number, street (NO P.O. Box) city zip code county state

Home Telephone _____ Date of Birth _____ ☐ Male ☐ Female

Do you have a handicapped license plate? No _____ Yes _____ If yes, License Plate No. _____
_____ Current Drivers License ID Number/Non Drivers License ID Number
_____ Do not have Drivers License/Non Drivers License

I hereby certify that the above statements are true and authorize the physician named to furnish any information requested by the Nassau County Office for the Physically Challenged concerning the diagnosis, prognosis and treatment of my described condition. I further acknowledge that I have read and understand the conditions of this application and the Handicapped Parking Permit, and shall observe and comply with same.

Date _____

SIGNATURE OF APPLICANT OR GUARDIAN

PART II MEDICAL CERTIFICATION INFORMATION (To be completed by a New York State licensed medical physician).

Name of Physician _____ Phone # _____

Address _____

Name of Patient _____ Physicians's
NYS Practicing License # _____

Please Check and describe below applicable condition(s):

"Severely Disabled Person". shall mean any person who has any one or more of the following impairments, disabilities or conditions which are **permanent** in nature.

- (a) _____ Has limited or no use of one or both lower limbs; (State disability and describe below:)
(b) _____ Has a Neuro-muscular dysfunction which severely limits mobility; (state disability and describe below)
(c) _____ Has a physical or mental impairment of condition which is other than those specified above, but is of such nature as to impose unusual hardship in utilization of public transportation facilities and such condition is certified by a physician duly licensed to practice medicine in this state as constituting an equal degree of disability (specifying the particular condition) so as to prevent such person from getting around without great difficulty in accordance with subdivision two of this section; or
(d) _____ A legally blind person

State Permanent diagnosis:

Please describe handicapped condition:

Temporary ? : _____ How long is Permit needed? : _____ Doctor must state walking device used _____

TEMPORARY DISABILITY: A temporarily disabled person is any person who is unable to ambulate without the aid of an assisting device, such as a brace, cane, crutch, prosthetic device, wheelchair, walker or other assistive device. (temporary permits are issued for periods of six months or less). New application required after that.

State temporary diagnosis: _____

I am an MD licensed to practice in New York State, and in my professional opinion, I believe the applicant's mobility impairing condition does warrant a handicapped Parking Permit, according to the above New York State definition of "SEVERELY DISABLED." Yes _____ No _____

Date: _____

SIGNATURE OF PHYSICIAN (No stamps accepted)(MD/DO/DPM/NP)

For Office Use Only

Permit No. _____ Date Issued _____ Expiration Date _____

Permanent ☐ Temporary ☐