DISABLED INDIVIDUAL SECTION

To be completed by or for the person with a disability

Full Name (Please Print) Last, First and Middle | Date of Birth

Street Address | Is applicant a Minnesota Licensed driver? ☐ Yes ☐ No

Does applicant have a Minnesota Identification Card? ☐ Yes ☐ No

MN License/ID Number

City | State | Zip

If no MN DL or ID please explain:

Has applicant ever had a Minnesota Disability Parking Certificate ☐ Yes ☐ No Minn. disability license plates? ☐ Yes ☐ No

List certificate and/or plate #:

☐ Check here if this application is for two parking certificates* ☐ Check here if this application is for a second parking certificate

**Two certificates are not an option if applicant has disability license plates* *Limit 2 per applicant without disability license plates.*

If applying for replacement, check reason: ☐ Lost ☐ Stolen ☐ Damaged ☐ Other; Please Explain:

In the Section above, complete the following:

Full Name (Last, First & Middle)
Date of Birth
Street Address
Check Yes or No if you are a Licensed Driver
City, State, Zip
Check Yes or No if you have a Minnesota ID Card
If Yes, enter your MN License/ID Card
Check Yes or No if you have ever had a Minnesota Disability Parking Certificate
Check Yes or No if you have ever had a Minnesota disability license plates
Check the box if this application is for two parking certificates

I hereby certify the above information is complete and accurate to the best of my knowledge. I also give permission to the Health Professional to supply the information requested.

Date: Signature:

*Non-residents may apply for temporary disability parking certificates or use the parking certificate issued in their state of residence.

Date and Sign

A Health Professional must fill out the Medical Statement Section below:

HEALTH PROFESSIONAL MEDICAL STATEMENT SECTION

Certificate Type:

Fee: $5 ea. ☐ **Temporary** 1 to 6 Months **Must Specify** →

Fee: $5 ea. ☐ **Short Term** 7 to 12 Months **Must Specify** →

No Fee ☐ **Long-Term** 13 to 71 Months **Must Specify** →

No Fee ☐ **Permanent Physical disability issued for 6 years**

Certificate Expiration Date

Month / Year

IMPORTANT!

If no date is indicated the certificate will be issued for the *minimum* duration of certificate type.

Deputy Stamp

☐ No Fee Paid (Perm.)
☐ $5 Fee Paid
☐ $10 Fee Paid (2 Tags)

The applicant must meet one or more of the definition(s) of a *"physically disabled person"* described below:

- Check which definition(s) the applicant meets. Cognitive disabilities do not qualify (see back)
- Listing "symptoms" such as **Back Pain, Leg Pain, etc.** will require further explanation, causing delays in issuance
- **Incomplete/missing information will cause significant delays in issuance**

The Applicant

1. ☐ Has a cardiac condition to the extent that the applicant's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association.
2. ☐ Uses portable oxygen
3. ☐ Has an arterial oxygen tension (PAO_2) of less than 60 mm/Hg on room air at rest.
4. ☐ Is restricted by a respiratory disease to such an extent that the applicant's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter.
5. ☐ Has lost an arm or leg and does not have or cannot use an artificial limb.

Disability Definitions 6-9 below must state the *specific diagnosis* of the condition causing disability.

6. ☐ Due to disability, uses a wheelchair or cannot walk without the aid of:
   Another Person; A Walker; A Cane; Crutches; Braces; A Prosthetic Device; or other Assistive Device ;
   (Specify Diagnosis of condition causing Disability):
7. ☐ Has a disability that would be aggravated by walking 200 feet under normal environmental conditions to an extent that would be life-threatening
   This condition is:
8. ☐ Due to disability cannot walk 200 feet without stopping to rest
   This condition is:
9. ☐ Cannot walk without a significant risk of falling
   This condition is:

Is the applicant qualified, in all medical respects, to exercise reasonable and ordinary control over a motor vehicle?

☐ Yes ☐ Yes, with adaptive equipment ☐ No, please specify:

Failure to answer this question will result in a request for a medical report.

I certify, by my signature as a licensed Physician, Physician's Assistant, Advanced Practice Registered Nurse, Chiropractor, or Physical Therapist that in my professional opinion *(Patient's Name)* meets the definition of physically disabled person and is entitled to a disability parking certificate. I would be guilty of a misdemeanor and subject to a fine of $500 for fraudulently certifying the applicant.

Signature & Title | Date | Print Name

Telephone Number | Street Address, City, State and Zip Code