

STATE OF FLORIDA
DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES
DIVISION OF MOTOR VEHICLES
Neil Kirkman Building - Tallahassee, FL 32399-0620

APPLICATION FOR DISABLED PERSON PARKING PERMIT

*****SUBMIT APPLICATION TO YOUR LOCAL COUNTY TAX COLLECTOR'S OFFICE OR LICENSE PLATE AGENCY*****

Please Print/Type Below

APPLICATION BY DISABLED PERSON (See Warning Below)

I certify that I am a disabled person as required by section 320.0848, Florida Statutes, with certification from either a Florida or out-of-state Physician, Osteopathic or Podiatric Physician, Optometrist (vision only) or Chiropractor; the Adjudication Office of the US Department of Veterans Affairs or the US Department of Defense.

Name of Disabled Person as printed on the Florida Driver License or Florida ID Card

Signature of Disabled Person, Parent or Guardian of Disabled Person

Date of Birth

Sex

Date Signed

Street Address

City

State

Zip Code

Florida Driver License Number or Florida Identification Card Number:

(Required for permanent and temporary parking permit)

If applicable, check one of the following:

I am a frequent traveler.

I am a quadriplegic.

LONG TERM DISABILITY

PHYSICIAN'S STATEMENT OF CERTIFICATION (See Warning Below)

PERMANENT PERMIT: This is to certify that _____ is legally blind or is a disabled person with a permanent disability(ies) that limits or impairs his/her ability to walk 200 feet without stopping to rest. The specific disability(ies) is/are checked below:

Legally blind (this is the only disability an Optometrist can certify).

***** NOTE: "Unable to walk 200 feet" is no longer a qualifying disability, unless it is due to one of the conditions listed below (a-f). ****

a. Inability to walk without the use of or assistance from a brace, cane, crutch, prosthetic device, or other assistive device, or without assistance of another person. If the assistive device significantly restores the person's ability to walk to the extent that the person can walk without severe limitation, the person is not eligible for the exemption parking permit.

b. The need to permanently use a wheelchair.

c. Restriction by lung disease to the extent that the person's forced (respiratory) expiratory volume for 1 second, when measured by spirometry, is less than one liter or the person's arterial oxygen is less than 60 mm/hg on room air at rest.

d. Use of portable oxygen.

e. Restriction by cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.

f. Severe limitation in a person's ability to walk due to an arthritic, neurological, or orthopedic condition.

TEMPORARY PERMIT: This is to certify that _____ is a person with a temporary disability (six months or less) that limits or impairs his/her ability to walk or is temporarily sight impaired. Due to the temporary specific disability(ies) checked above, recommend a disabled person parking permit to be issued from _____ (date) through _____ (date).

WARNING: Any person who knowingly makes a false or misleading statement in an application or certification under section 320.0848, Florida Statutes, commits a misdemeanor of the first degree, punishable as provided in section 775.082 or 775.083, F.S. The penalty is up to one year in jail or a fine of \$1,000 or both.

Print/Type Name of Certifying Authority

Signature

Date Signed

Business Street Address

(Area Code) Telephone Number

City

State

Zip Code

Certification or License No. (Required)

of a Physician, Osteopathic or Podiatric Physician, Chiropractor, Optometrist or an

Advanced Registered Nurse Practitioner/Physician's Assistant from a facility operated by the US Department of Veterans Affairs.

LICENSED IN THE STATE OF: _____

Please Print/Type

APPLICATION BY AN ORGANIZATION (See Warning Above)

This is to certify that _____ provides regular transportation service to disabled persons having disabilities that limit or impair their ability to walk or are certified to be legally blind.

Number of vehicles in fleet for this purpose _____

Signature of Organization's Authorized Representative

Date Signed

Street Address

City

State

Zip Code

FEID NUMBER: _____

TAX COLLECTOR USE ONLY

Agency Personnel Processing this Application

County

Agency

Date

HSMV 83039 (Rev. 07/04) S