



# 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/](http://www.ok.gov/dps/) or call (405)425-2693.