

Dear Disabled Parking Permit Applicant:

The Town of Islip Department of Human Services, Division of Services to the Disabled, is pleased to provide you with an application for a Special Vehicle Identification Parking Permit. The New York State Department of Motor Vehicles requires that a doctor's note, specifically detailing the diagnosis and limitations of your disabling condition, be submitted with your application.

WE REQUEST THAT YOU INSTRUCT YOUR DOCTOR TO CLEARLY PRINT OR TYPE WITHOUT ABBREVIATING. WE REQUIRE SPECIFIC INFORMATION ON YOUR DISABLING CONDITIONS, AND HOW IT AFFECTS YOUR ABILITY TO AMBULATE. THE DOCTOR MUST INDICATE WHETHER YOUR CONDITION IS PERMANENT OR TEMPORARY.

**\*IMPORTANT - PLEASE READ\***

- ★ *YOUR PHYSICIAN MUST INCLUDE A DIAGNOSIS ON A PRESCRIPTION PAD OR A LETTER ON HIS/HER OFFICE LETTERHEAD. WE WILL NOT ISSUE ANY PERMITS WITHOUT THIS DOCUMENTATION.*
- ★ *PLEASE BE ADVISED THAT NO PERMIT WILL BE ISSUED WITHOUT A COPY OF YOUR NYS DRIVER'S LICENSE, NON DRIVER'S ID CARD OR A LETTER EXPLAINING THAT YOU ARE NOT IN POSSESSION OF ANY OF THESE ITEMS.*
- ★ PLEASE MAKE SURE WHEN YOU INCLUDE ONE OF THE ABOVE PROOFS OF IDENTITY THAT IT MATCHES YOUR PRESENT ADDRESS. IF NOT, PLEASE PROVIDE ANOTHER FORM OF DOCUMENTATION PROVING YOUR RESIDENCY IN THE TOWN OF ISLIP.
- ★ PLEASE NOTE: MEDICAL CERTIFICATION MAY ONLY BE COMPLETED BY A MEDICAL DOCTOR (MD), A DOCTOR OF OSTEOPATHY (DO), OR A DOCTOR OF PODIATRIC MEDICINE (DPM). A PODIATRIST MAY ONLY ATTEST TO INJURIES OR DISABLING CONDITIONS THAT ARE BELOW THE ANKLE. MEDICAL CERTIFICATION CANNOT BE CERTIFIED BY A CHIROPRACTOR (DC). SIGNATURE STAMPS ARE NOT ACCEPTABLE. YOUR PHYSICIAN MUST PROVIDE AN ORIGINAL SIGNATURE WHEN CERTIFYING THIS APPLICATION FOR A DISABLED PARKING PERMIT.
- ★ PLEASE NOTE THAT ALL BLUE PARKING PERMITS MUST BE RENEWED NO LATER THEN THREE MONTHS AFTER THE EXPIRATION DATE. IF NOT RENEWED WITHIN THREE MONTHS, A NEW APPLICATION MUST BE FILED.

**SPECIAL NOTICE & CAUTION:** New York State Traffic Law states that this permit shall be for use exclusively in a vehicle in which the person to whom it has been issued is being transported and such permit shall not be transferable and shall be forfeited if presented by any other person. Any abuse by any person, facility or agency to whom such a permit has been issued of any privilege, benefit, precedence or consideration granted pursuant to the issuance of such permit, shall be sufficient cause for revocation of said permit

§1203-c(ii).

If your application is approved, you will receive a blue (permanent) or red (temporary) plastic permit which is to be hung on your rear view mirror when parked. If you have any questions about the application, please call the Services to the Disabled Office at (631) 224-5335 (voice) or (631) 224-5397 (TTY), or you can visit us at 401 Main St., Rm 135, Islip which is located in the back of the building.

Sincerely,

Angel Santana  
Director of Handicapped Services

TOWN OF ISLIP  
DIVISION OF SERVICES TO THE DISABLED

APPLICATION FOR DISABLED PARKING PERMIT  
(Chapter 838 of Motor Vehicle Law, 1977)

FOR OFFICE USE ONLY
NYS #: _____
LICENSE #: _____
DIAG. CODE: _____

The following is to be completed by the applicant or the applicant's legal guardian or primary care giver. Please note that failure to completely answer ALL of the questions below, may result in a delay of issuance of a Parking Permit.

PLEASE BE INFORMED THAT IT IS NOW A NEW YORK STATE REGULATION THAT YOU MUST PROVIDE A PHOTO COPY OF A VALID NYS DRIVER'S LICENSE OR NON DRIVER'S I.D. IF YOU DO NOT HAVE EITHER OF THESE YOU MUST PROVIDE A SIGNED LETTER TO THAT EFFECT.

Date: \_\_\_\_\_ New Applicant: \_\_\_\_\_ Renewal: \_\_\_\_\_ Prior Permit # \_\_\_\_\_

Name of Disabled Person: \_\_\_\_\_  
Last First M.I.

Mailing Address: \_\_\_\_\_  
Address Town Zip

Home Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Do you use any of the following? Crutches \_\_\_\_\_ Cane \_\_\_\_\_ Walker \_\_\_\_\_ Wheelchair \_\_\_\_\_  
Portable Oxygen \_\_\_\_\_ Other: \_\_\_\_\_

I certify that the above disability, impairment or condition is:  
PERMANENT \_\_\_\_\_ TEMPORARY \_\_\_\_\_  
and the statements contained herein are true. I further acknowledge that I have read and understood the conditions of the application and the disabled parking permit.

Date: \_\_\_\_\_  
Signature of Applicant or Primary Care Giver

PLEASE NOTE: A PHYSICIAN MUST PROVIDE A DIAGNOSIS, WRITTEN ON A PRESCRIPTION PAD OR ON LETTERHEAD, TO BE SUBMITTED WITH THIS APPLICATION.

Name of Physician: \_\_\_\_\_ License # \_\_\_\_\_  
PLEASE PRINT

Address: \_\_\_\_\_ Telephone # \_\_\_\_\_

Name of Disabled Person: \_\_\_\_\_

**MEDICAL CERTIFICATION:** This section must be completed by a Medical Doctor, Doctor of Osteopathy or Doctor of Podiatric Medicine. Please indicate below the disabling condition which necessitates that the above named applicant be granted a disabled parking permit; thereby entitling the individual to special parking privileges. INDICATE IF THIS CONDITION IS PERMANENT OR TEMPORARY, AND DESCRIBE THE LIMITATIONS WHICH CAUSE DIFFICULTY IN AMBULATION.

DIAGNOSIS: \_\_\_\_\_  
(PLEASE PRINT OR TYPE – DO NOT ABBREVIATE OR USE OFFICE CODES)

IN REFERENCE TO AMBULATION, HOW IS THE APPLICANT AFFECTED BY THIS DIAGNOSIS?  
\_\_\_\_\_

Please certify if the patient's disability is permanent or temporary.  
\_\_\_\_\_ Permanent \_\_\_\_\_ Temporary & Expected Recovery Date \_\_\_\_/\_\_\_\_/\_\_\_\_ .

**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, another person, wheelchair, walker or other assistive device. (Temporary permits are issued for periods of six months or less.)

**PERMANENT DISABILITY:** A "severely disabled person" is any person with one or more of the PERMANENT impairments, disabilities or conditions listed below, which limit mobility.(Check all that apply)

- \_\_\_\_\_ Uses portable oxygen.
- \_\_\_\_\_ Legally blind.
- \_\_\_\_\_ Limited or no use of one or both legs.
- \_\_\_\_\_ Unable to walk 200 ft. without stopping.
- \_\_\_\_\_ Neuromuscular dysfunction that severely limits mobility.
- \_\_\_\_\_ Class III or IV cardiac condition (American Heart Assoc. Standards)
- \_\_\_\_\_ Severely limited in ability to walk due to an arthritic, neurological or orthopedic condition.
- \_\_\_\_\_ Restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg of room air at rest.
- \_\_\_\_\_ Has a physical or mental impairment or condition not listed above which constitutes an equal degree of disability, and which imposes unusual hardship in the use of public transportation and prevents the person from getting around without great difficulty.

DATE: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN  
Signature Stamp not acceptable