Application for a New York State Parking Permit for People with Disabilities

GENERAL INSTRUCTIONS

It is now required that you, the applicant provide us with a valid copy of your New York State Driver's License or a New York State Non Driver’s Identification issued by the New York State Department of Motor Vehicles.

For more information about obtaining a New York State Driver's License or New York State Non-Drivers Identification card, please call the New York State Department of Motor Vehicles at: 718 / 966-6155 or 212 / 645-5550.

You can now apply on-line for a New York State Disability Parking Permit at the below website address, or mail your application in to our office.

1) You are eligible to receive a New York State disability parking permit for the disabled issued by the Department of Transportation's Parking Permits for People with Disabilities Unit if you are a New York City resident and have a qualifying, severe mobility impairment as certified by a NY State licensed physician or podiatrist.

2) You do not have to be a driver or registered owner of a vehicle to get a permit. Legally blind persons and disabled children are eligible for permits.

3) The permit is valid everywhere in New York State where there are designated parking spaces for people with disabilities. It is also valid in all other states and Canadian provinces. However, its use never allows you to disobey state or local parking regulations. The permit may be used to park in disabled marked parking spaces only when the vehicle is being used to transport the disabled person.

4) Any person who has been issued a disability parking permit, who abuses any privilege, benefit, precedence, or consideration arising from possession of the permit, may have it revoked.

5) The application is to be signed by the person with the disability. Signatures are allowed by a parent or guardian only if the applicant’s disability does not allow him/her to sign, or if the applicant is a minor.

6) Send your completed application (applicant’s section and medical certification) to the issuing agent for city residents: Permits & Customer Service (PPPD Unit), NYC Department of Transportation, 30-30 Thomson, 2nd floor, Long Island City, New York 11101.

7) Applicant: Do you have a license plate for people with disabilities?
   Please check one: _____Yes _____No

8) If "Yes", and you attach a copy of your NY State vehicle registration to this application, you do not have to be recertified by a physician. Just fill out the disabled person's personal information on the reverse side of this form and return it with the copy of your disabled plate registration to this office. (If it is a disabled vanity plate you must also send in a photo of it.)

Please keep a copy of this application for your records.
To apply for a New York State Disability Parking Permit

Please fill out this form completely
Please Print or Type

Please enter the applicant’s (disabled person’s) personal information below.

Name: ___________________________________________ (First) ___________________________________________ (Last)

Address: ___________________________________________ Apt#: ___________

Borough/Post Office: _____________________, NY Zip Code: ____________

Telephone #: Home #: (___)-____-______ Work #: (___) ____- _______

Date of Birth: ____-____-_____
Social Security Number: ___ -___ -______
(Providing your social security number is no longer optional. Clients must provide their full Social Security number).

New York State issued Drivers License ID# ________________ Exp. Date _________________

New York State issued Non-Driver ID# _____________________ Exp. Date _________________

I certify that the information contained in this application is true and that I have read and understood the conditions described on the reverse side of this form and will comply with them if issued a permit.

IMPORTANT: False statements are punishable under Section 210.45 of the Penal Law
MUST SIGN BELOW:

__________________________________________________ Date: ___ / ___ / ___

Applicant’s signature or signature of parent or guardian
This section is to be completed by a N.Y. State licensed Physician only (MD, DO, DPM)

Medical Certification for ________________________________

(Name of patient)

Name of Physician: ________________________________

(Please print clearly)

Address: _____________________________________________

City: _______________________ State: __________ Zip Code: _______________

NY State Prof. License # _______________MD______DO_______DPM________

Telephone: (______)-_______-________

Please print or type in diagnosis (no attachments will be accepted).
Is this condition: Permanent ____ or Temporary ____ (Physician please check one).
Diagnosis must severely affect walking; if permanent it must be chronic in nature.

If the condition is temporary, please give expected recovery date here ___ /___ / ____
Must indicate what assistive device is needed for ambulation.

DIAGNOSIS:

EXPLAIN BELOW HOW SEVERELY THE CONDITION AFFECTS THE ABILITY TO WALK?

Physician please read before signing:
By signing below you are certifying that the information you are providing is true and complete, any False statements or deliberate misinformation are punishable under Section 210.45 as per the NYS Penal Law; including fines. In addition any false statements on your behalf will also be reported to the New York State Department of Health Office of Professional Medical Conduct.

>>>Signature of Physician ________________________________ Date:___ / ___ / _____
(Stamped signature not acceptable)

For PPPD office use: Application #___________________________