NOTE TO *CUSTOMERS* AND *DOCTORS*

It is important for you to know that making a false statement, or providing misinformation on an application to obtain or facilitate the receipt of a parking permit or license plates for persons with a disability is subject to **fines ranging from $250 to $1,000** under Section 1203-a(4) of the NYS Vehicle and Traffic Law and is punishable as a **misdemeanor** under Section 210.45 of the NYS Penal Law.

Customers Requesting License Plates, or a Parking Permit, for Persons with a Disability

By signing Part 1 of this application, you are certifying:

- that the information you provide on this application is true;
- that you have read and understand the "Conditions for Using License Plates and Parking Permits" stated on form MV-664.3; and
- that you agree to comply with those conditions.

Doctors Providing Medical Information in Support of an Application for License Plates, or a Parking Permit, for Persons with a Disability

By signing Part 2 of this application, you are certifying:

- that the medical information you are providing is true and complete; and
- that, in your opinion, the person named in Part 1 of the application is medically qualified to receive license plates, or a parking permit, for persons with a disability, according to the medical criteria specified in Part 2.

MV-664 1 (3/02)

New York State Department of Motor Vehicles

APPLICATION FOR LICENSE PLATES OR PARKING PERMITS FOR PERSONS WITH SEVERE DISABILITIES

Part 1 INFORMATION ABOUT PERSON WITH DISABILITY —*(Please print, and sign by the arrow.)*

Last Name	First	M.I.	Telephone No. ( )

Address: No. and Street	Apt. No.	City	State	Zip Code

Date of Birth / / ☐ Male ☐ Female I am applying for ☐ License Plates *(Apply to DMV.)* ☐ Parking Permit *(Apply to local issuing agent.)*

Do you have license plates for persons with disabilities? ☐ Yes - My license plate number is: _____ ☐ No

See Note on Page 2

_____ _____

(Signature of Person with Disability or Signature of Parent or Guardian) — *If signed by a parent or guardian, please state your relationship to the person with the disability after your signature.* (Date)

Part 2 MEDICAL CERTIFICATION—*This section must be completed only by a Medical Doctor (MD), Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM) . Please certify whether the patient's disability is permanent or temporary.*

Check the box(es) that describe the disability, and fill in the diagnosis:

☐ TEMPORARY DISABILITY: A person with a temporary disability is any person who is temporarily **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.) **Expected Recovery Date** ____/____/____

Diagnosis: _____

What assistive device is needed? _____

☐ 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.

Diagnosis: _____ Please **check the conditions 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. **EXPLAIN HOW THIS DISABILITY LIMITS FUNCTIONAL MOBILITY.**

_____

_____

_____

MD/DO/DPM Name	Professional License No.
MD/DO/DPM Address	Telephone No. ( )

See Note on Page 2

_____ _____

(MD/DO/DPM Signature) (Date)

Part 3 FILE INFORMATION *(For Issuing Agent Use Only):*

PERMIT: ☐ Permanent ☐ Temporary **Parking Permit No.** _____ Issuance Date: _____

☐ First ☐ Second Expiration Date: _____

☐ Denied ☐ Revoked Reason: _____ _____ (Date)

_____ _____

(Issuing Agent) (Locality)