Department of Public Safety

Handicapped Parking Placard Application

Driver Compliance Division

The Department of Public Safety requires approximately 10 business days after receipt to process the application.

This form must be completed by applicant (patient) and physician before a handicap placard can be issued.

I hereby make application to the Department of Public Safety for a handicapped parking placard. I understand I must display the official placard on the rearview mirror of my vehicle. I further understand this item 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, or unauthorized use of, a handicapped placard is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not more than $500.

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/ID number: _____ **Phone:** _____
(Home)

NOTICE: I understand that by signing and submitting this form, my ability to operate a motor vehicle may be reviewed 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 (required):

The following section must be completed by a physician licensed to practice medicine or surgery, osteopathic medicine, chiropractice, podiatric medicine, or optometry; a licensed physician assistant; or a licensed and certified advanced registered nurse practioner.

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, or
- ☐ **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, or
- ☐ **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 Diagnosis: _____

Type of placard requested: _____ **5-YEAR PLACARD**

TEMPORARY ISSUED FOR UP TO 6 MONTHS _____ **TEMPORARY PLACARD** **EXPIRATION DATE:** _____

I certify that the applicant's (patient's) physical disability described above is accurate, and the care and treatment 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: _____

FOR DPS OFFICE ONLY

Expiration date: _____ **Date issued:** _____ **Placard number:** _____

Mail this completed application to:
Department of Public Safety
Driver Compliance Div. - Handicap
P.O. Box 11415
Oklahoma City, OK 73136-0415

If you have any questions, please call (405) 425-2290.