

Persons with Disabilities Certification for Parking Placard

DIRECTIONS: Both sides of this document must be signed and completed. Side A must be completed by the physician and Side B must be completed by the applicant.

DEFINITION: "PERSONS WITH DISABILITIES" (625 ILCS 5/1-159.1)

"A natural person who, as determined by a licensed physician: (1) cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device; (2) is restricted by lung disease to such an extent that his or her forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 mm/hg on room air at rest; (3) uses portable oxygen; (4) has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV, according to the standards set by the American Heart Association; or (5) is severely limited in the person's ability to walk due to an arthritic, neurological, or orthopedic condition; or (6) cannot walk 200 feet without stopping to rest because of one of the above 5 conditions; or (7) is missing a hand or arm or has permanently lost the use of a hand or arm."

Please fill in the name of the person with the disability, state the diagnosis, and indicate the impairments below.

Name of Person with Disabilities: _____

Diagnosis: _____

NOTE: "Cannot walk 200 feet without stopping to rest" is no longer a qualifying disability unless it is related to one of the following conditions below.

- ____ Is restricted by lung disease to such a degree that the person's forced (respiratory) expiratory volume (FEV) in one second, when measured by spirometry, is less than one liter.
- ____ Uses portable oxygen.
- ____ Has a Class III or Class IV cardiac condition according to the standards set by the American Heart Association.
- ____ Cannot walk without the assistance of another person, prosthetic device, wheelchair or other assistive device.
- ____ Is severely limited in the person's ability to walk due to an arthritic, neurological or orthopedic condition.
- ____ Has permanently lost the use of or is missing a hand or arm.

LENGTH OF DISABILITY: (Check one)

- Disability is permanent Disability is temporary; must state duration (maximum 6 months) _____

I hereby certify that the physical condition of the person with disabilities listed herewith constitutes him/her as a person with disabilities as described under 625 ILCS 5/1-159.1. **WARNING:** Any person who knowingly misuses or makes a false or misleading statement on an application may be fined up to \$1,000. **PHYSICIANS: Do not sign this form if the patient does not meet the above definition. (NOTE: If certification form is signed by a licensed physician assistant or advance practice nurse, the name and license number of the supervising physician is required.)**

Physician's Signature Date Physician's License Number

Supervising Physician's Name Date Supervising Physician's License Number

PLEASE PRINT OR TYPE BELOW:

Physician's Name _____

Address _____

City _____ State _____ ZIP _____

Telephone () _____

Please mail all required documentation to: Secretary of State, Persons with Disabilities License Plates/Placard Unit, 501 S. Second St., Rm. 541, Springfield, IL 62756, www.cyberdriveillinois.com.

DIRECTIONS: Both sides of this document must be signed and completed in its entirety in order for the application to be processed. Complete Part 1 if the person with disabilities is applying for disability plates and/or a parking placard. Complete Parts 1 and 2 if the parent, immediate family member or legal guardian of the person with disabilities is applying for disability plates.

PART 1. PERSON WITH DISABILITIES:

I hereby apply for:

____ Person with Disabilities License Plates (Application and fee for registration must accompany this form. Fee is based upon the current plate expiration, date of purchase of vehicle if newly acquired, or the date of application, whichever is applicable.) **APPLICANTS MUST HAVE A PERMANENT DISABILITY TO OBTAIN DISABILITY PLATES.**

____ Persons with Disabilities Parking Placard

under the statutory provision (625 ILCS 5/1-159.1), and certify that my physical condition entitles me to the issuance thereof. I also am aware that the person with disabilities parking device (plates or parking placard) must not be used unless I am the driver or passenger in the vehicle.

_____ Date _____ Applicant's Signature

WARNING: MISUSE OF OR FALSE APPLICATION FOR PERSONS WITH DISABILITIES PLATES OR PARKING PLACARDS may result in revocation of the plates or placard, a 30-day driver's license suspension, and a fine of up to \$1,000. The authorized holder of the disability plates or parking placard must be present and must enter or exit the vehicle at the time parking privileges are being used.

PLEASE PRINT OR TYPE BELOW:

Name of Person with Disability	____ OR ____ Male Female	Date of Birth (Month/Day/Year)
Address	City	ZIP
Driver's License or State ID Card Number of Person with Disability	Telephone Number	

PART 2. DISABILITY LICENSE PLATES FOR PARENT, IMMEDIATE FAMILY MEMBER OR LEGAL GUARDIAN ONLY:

I hereby apply for disability license plates as the parent, legal guardian or other family member of the individual with a disability. The above named person with disabilities owns no vehicles and relies frequently on me for his/her mode of transportation.

Parent's, Legal Guardian's OR Family Member's Name	Date	
Address	City	ZIP
Telephone Number ()	Relationship to Person with Disability	

.....FOR OFFICE USE ONLY.....

Parking Placard Number _____ Expiration Date _____
 Issued By _____ Issue Date _____