

Muscogee Creek Nation Physical Disability Parking Placard Application

Sections 1 and 2 of this form must be completed by applicant (patient) and physician before a disability placard can be issued. If you are only seeking a replacement placard which has been lost, stolen or destroyed, only Section 1 must be completed.

Type of placard requested: New Renewal Replacement (Lost/Stolen/Destroyed)

Number of placards requested: 1 placard 2 placards (Limit 1 replacement placard if lost, stolen or destroyed during the term of the original placard)

I hereby make application to the Muscogee Creek Nation Tag Office for a physical disability parking placard. I understand I must display the official placard on the rear view mirror upon parking. I understand the placard 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 a disability parking placard, or makes or allows unauthorized use thereof, is guilty of a misdemeanor and upon conviction shall be punished by a fine of 500. Attach a copy of your updated Citizenship Card, must have photo on Citizenship Card and not be expired.

Section 1 (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 or State Identification Card Number: _____ Phone: _____
(Home)

NOTICE: I understand that by signing and submitting this form, my ability to operate a motor vehicle may be reviewed by the Department 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 of Applicant or Person Responsible for Applicant (required): _____

NOTICE: Department shall only consider new or renewal applications submitted within 60 (sixty) days of the date of the physician signature in section 2

Section 2

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

Physician's statement concerning the above-named applicant (patient):

- | | |
|---|---|
| <input type="checkbox"/> A. Cannot walk 200 feet without stopping to rest, or | <input type="checkbox"/> 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 |
| <input type="checkbox"/> B. Cannot walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistant device, (Must circle appropriate response) | <input type="checkbox"/> F. Is severely limited in his or her ability to walk due to an arthritic neurological, or orthopedic condition, or complications due to pregnancy, (Must circle appropriate response) |
| <input type="checkbox"/> 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 | <input type="checkbox"/> G. Is certified legally blind, or |
| <input type="checkbox"/> D. Must use portable oxygen, or | <input type="checkbox"/> 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

Type of placard approved by signing physician

- Temporary Placard - issued for a maximum of 6 months. Select expiration date for placard not to exceed 6 months _____
- 5-Year Placard

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

Physicians must indicate the type of placard and provide all information along with their signature.

\$7.00 each

Date Issued ----- Plac # ----- Roll # ----- Exp Date -----