VILLAGE OF CEDARHURST
NEW YORK STATE DISABLED PARKING PERMIT APPLICATION
200 CEDARHURST AVENUE, CEDARHURST, NY 11516

PART I (To be completed by applicant) PLEASE PRINT

Applicant's Name____

Address____

You must provide proof of residency if name does not appear on our tax roll

Date of Birth______________**Telephone #**_____________/______________/______________
Home Business Cell

Drivers License I.D. No._________________
and copy of license

I hereby certify that the above statements are true, and authorize the physician named in Part II to furnish any information to this office concerning the diagnosis, prognosis and treatment of my described condition.

I further acknowledge that I have read and understand the conditions of this application and the Disabled Parking Permit, and I shall observe and comply with same.

Date______________________________ ____________________________________
Signature of Applicant or Guardian

PART II (To be completed by a MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY)

Physician's Name__________________________________**License #** ______________________

Address____**Phone #**_______________________

_______________________________________**has one or more of the following impairments:**
ANSWER ALL FOUR QUESTIONS:

1. **Please check applicable condition(s):**

   _______**limited or no use of one or both lower limbs.**
   _______**neuro-muscular dysfunction which severely limits mobility.**
   _______**physical or mental impairment or condition which is other than those specified above, but imposes unusual hardship in utilization of public transportation facilities and such condition prevents applicant from getting around without great difficulty.**
   _______**a blind person.**

2. **Please describe disability:**____

   ____

3. **Describe limitations in ambulation (include use of walking aids)** ___________

   ____

4. **This condition is**_________**Permanent**_________**Temporary.**
   If temporary, please indicate the approximate length of time your patient will require the permit__________**months.**

I am an MD or a DO, licensed to practice in New York State, and in my professional opinion, I believe the applicants condition does warrant a Disability Parking Permit.

_____________________________________ **Date:**_________________
Signature of Physician (no stamp accepted)