

APPLICATION FOR DISABILITY PARKING CERTIFICATE

FOR
OFFICE
USE ONLY

To be completed by: DISABLED INDIVIDUAL
Any misuse or reproduction of the certificate issued will result in the revocation of the parking privilege.

Full Name (Please Print)	Date of Birth
Address	Are you a licensed driver
City, State, Zip	Drivers License Number _____

I hereby certify the above information is complete and accurate to the best of my knowledge. I also give permission to my physician to supply the information requested.

Signature _____ Date _____

To be completed by: PHYSICIAN/CHIROPRACTOR

To be eligible for a disability parking certificate the applicant must meet one or more of the below described definition(s) of a "physically handicapped person." Check which definition(s) the applicant meets.

- 1. The applicant has a cardiac condition to the extent that the applicant's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association
- 2. The applicant uses portable oxygen;
- 3. The applicant has an arterial oxygen tension (PAO2) of less than 60 mm//Hg on room air at rest;
- 4. The applicant is restricted by a respiratory disease to such an extent that the applicant's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter;
- 5. Because of the disability applicant cannot walk without the aid of another person, a walker, a cane, crutches, braces, a prosthetic device, or a wheel chair; **(PLEASE CIRCLE IMPAIRMENT)**
- 6. Because of disability applicant cannot walk 200 feet without stopping to rest.*
- 7. Because of disability applicant cannot walk without a significant risk of falling.*
- 8. The applicant has lost an arm or a leg and does not have or cannot use an artificial limb.
- 9. Because applicant has a condition that would be aggravated to such an extent that walking 200 feet would be life threatening.*

*Must specify disability _____

THIS DISABILITY IS: Temporary* Permanent
*IF TEMPORARY, STATE DURATION _____

I certify, by my signature as a licensed physician or chiropractor, that _____, in my professional opinion, meets the definition(s), I have checked above and is entitled to the applied for parking certificate.

<p>RETURN TO: RED LAKE BAND OF CHIPPEWA INDIANS MOTOR VEHICLE REGISTRATION P.O. BOX 573 RED LAKE, MN 56671 (218) 679-3341</p>	Physician's or Chiropractor's Signature & Title
	Print Physician/Chiropractor Name
	Address:
	Telephone Number:

MAKE REMITTANCE PAYABLE TO THE
RED LAKE BAND OF CHIPPEWA INDIANS

APPLICATION FEE \$5
PLEASE NOTE 1ST DUPLICATE PERMIT = \$10.00. 2ND DUPLICATE PERMIT \$15.00.
(ALSO NEED NEW APPLICATION SIGNED BY PHYSICIAN)