



# APPLICATION FOR DISABILITY PARKING PLACARD OR DISABILITY PLATE

State Form 42070 (R6 / 7-07)

INDIANA BUREAU OF MOTOR VEHICLES

The information in this document is confidential according to IC 9-14-5.

\* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is voluntary and you will not be penalized for refusal.

INSTRUCTIONS: Please print or type

## APPLICANT INFORMATION

Name of applicant (first, last, middle initial) (if corporation or agency, list name)

Address (number and street, city, state and ZIP code)

Social Security number \*

Federal Identification number

Date of birth (month, day, year)

## SECTION 1 - APPLICATION FOR DISABILITY PLATE

(You must present this form at a License Branch within your county of residence to receive a Disability Plate)

A. I am qualified to receive a Disability Plate because (check one):

1.  I have permanent disability that requires the use of a wheelchair, walker, braces or crutches.
2.  I have permanently lost the use of one or both legs.
3.  My mobility is permanently restricted due to a pulmonary or cardiovascular disability, arthritic condition, orthopedic condition or neurological impairment. This requires the completion of SECTION 3A - "Practitioner's Certification" on the bottom of this form (a separate attachment is not acceptable).
4.  I am permanently blind or visually impaired as defined by IC 12-7-2-21 or 12-7-2-198. This requires the completion of SECTION 3B - "Practitioner's Certification" on the bottom of this form by an optometrist or ophthalmologist (a separate attachment is not acceptable).
5.  I have been issued a permanent parking placard under IC 9-14-5.

I affirm under the penalties of perjury that the foregoing representations are true (parent or legal guardian must sign for persons under the age of sixteen).

### FOR BRANCH USE ONLY

Signature

Date (month, day, year)

Plate number

NOTE: A person who knowingly and falsely represents himself as having the qualification to obtain a disability placard commits a Class C misdemeanor pursuant to IC 9-18-22-6.

B. If plate is issued to person other than the disabled person then the recipient of the plate must complete the following:

Name of applicant (first, last, middle initial)

Social Security number \*

Address (number and street, city, state and ZIP code)

I affirm under the penalties of perjury that the vehicle to be registered with the plate applied for on this form is used regularly to transport the person qualifying herself / himself as disabled on this form.

Signature

Date (month, day, year)

## SECTION 2 - APPLICATION FOR DISABILITY PARKING PLACARD

(You must present this form at any Indiana License Branch to obtain a Disability Parking Placard.)

A. I am: (check one)

- |   |   |
|---|---|
| 1. <input type="checkbox"/> Applying for a new Disability Placard       | 2. <input type="checkbox"/> Renewing my Disability Placard                |
| 3. <input type="checkbox"/> Applying for a duplicate Disability Placard | 4. <input type="checkbox"/> Applying for an additional Disability Placard |

B. I am qualified to receive a Disability Placard because (check one):

1.  I have a disability that requires the use of a wheelchair, walker, braces or crutches.
  - a.  Temporarily
  - b.  Permanently
2.  I have lost the use of one or both legs.
  - a.  Temporarily
  - b.  Permanently
3.  My mobility is restricted due to a pulmonary or cardiovascular disability, arthritic condition, orthopedic condition or neurological impairment. (This requires the completion of SECTION 3A of the Practitioner's Certification on the back of this form. A separate attachment is not acceptable.)
  - a.  Temporarily
  - b.  Permanently

**SECTION 2 - CONTINUED**

**B.** I am qualified to receive a Disability Placard because (*check one*):

- 4.  I am permanently blind or visually impaired as defined by IC 12-7-2-21 or 12-7-2-198. (*This requires the completion of SECTION 3B of the Practitioner's Certification below by an optometrist or ophthalmologist. A separate attachment is not acceptable.*)
- 5.  the above-named corporation, partnership or unincorporated association operates programs (*including the provision of transportation*), or facilities for persons with disabilities and is empowered by the State of Indiana or its political subdivision to do so.
- 6.  of a government entity / government contract. Beginning date (*month, day, year*) \_\_\_\_\_ Ending date (*month, day, year*) \_\_\_\_\_

I affirm under the penalties of perjury that the foregoing representations are true (*parent or legal guardian must sign for persons under the age of sixteen*).

Signature	Date ( <i>month, day, year</i> )
-----------	----------------------------------

NOTE: A person who knowingly and falsely represents himself as having the qualification to obtain a disability placard commits a Class C misdemeanor pursuant to IC 9-14-5-9.

**SECTION 3 - PRACTITIONER'S CERTIFICATION**

**Please complete Section 3A or 3B and sign in Section 3C.**

**Applicant is responsible for any costs associated with completion of certification.**

**SECTION 3A - PHYSICIAN'S AND CHIROPRACTOR'S CERTIFICATION**

**A.** I certify that \_\_\_\_\_ is severely restricted in mobility due to a pulmonary or cardiovascular disability, arthritic condition, orthopedic condition or neurological impairment. This severe restriction in mobility is (*check one*)  permanent  temporary and is expected to end on \_\_\_\_\_ 20 \_\_\_\_\_. (*NOTE: The expected date must be filled in for temporary disabilities.*)

**B.** I am (*check one and sign Section 3C*):

- 1.  A physician having an unlimited license to practice medicine in Indiana.
- 2.  A physician who is a commissioned medical officer of the armed forces of the United States or the United States Public Health Service.
- 3.  An advanced practice nurse licensed under IC 25-23.
- 4.  A chiropractor licensed under IC 25-10-1.
- 5.  A podiatrist licensed under IC 25-29-1.
- 6.  A physician who is a medical officer of the Veterans Administration of the United States.

**SECTION 3B - OPHTHALMOLOGIST'S AND OPTOMETRIST'S CERTIFICATION**

**A.** I certify that \_\_\_\_\_ is permanently blind or visually impaired as defined by IC 12-7-2-21 or 12-7-2-198.

**B.** I am (*check one and sign Section 3C*):

- 1.  An ophthalmologist licensed to practice in Indiana.
- 2.  An optometrist licensed to practice in Indiana.

**SECTION 3C - PRACTITIONER'S SIGNATURE**

Signature of practitioner	Date ( <i>month, day, year</i> )
Printed name ( <i>first, last, middle initial</i> )	
Address ( <i>number and street, city, state and ZIP code</i> )	
Telephone number (     )	License number

**FOR BRANCH USE ONLY**

**PLACARD NUMBER(S)**

1	
2	
3	
4	
5	
Date of application ( <i>month, day, year</i> )	
Date of application ( <i>month, day, year</i> )	