

HANDICAPPED PARKING PLACARD APPLICATION

THIS FORM MUST BE FULLY COMPLETED BY APPLICANT AND PHYSICIAN BEFORE A HANDICAP PLACARD CAN BE ISSUED.

THERE IS A \$10 PROCESSING FEE
MAKE CHECK PAYABLE TO: OSAGE NATION TAX COMMISSION

I hereby make application to the Osage Tax Commission for a handicapped parking placard. I understand I must display the official placard on the rearview mirror of my vehicle. I further understand this item may only be displayed in motor vehicles either operated by me, or in which I am a passenger. I further understand that any person who knowingly makes false application for or unauthorized use of a handicapped placard is subject to a civil fine not to exceed \$500.00.

PLEASE PRINT OR TYPE

APPLICANT'S (PATIENT) NAME: _____ DATE OF BIRTH: _____
(First) (Middle) (Last)

MAILING ADDRESS: _____
(Street or P.O. Box) (City) (State) (Zip)

DRIVER LICENSE NUMBER: _____ PHONE: _____

SIGNATURE: _____

THE FOLLOWING MUST BE COMPLETED BY A PERSON LICENSED TO PRACTICE MEDICINE, SURGERY, OSTEOPATHIC, CHIROPRACTIC OR PODIATRIC MEDICINE, OR OPTOMETRY:

THE ABOVE-NAMED APPLICANT (PATIENT):

- ☐ A. Cannot walk two hundred (200) feet without stopping to rest, or
- ☐ B. Cannot walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistant device, or
- ☐ C. Is restricted to such an extent that the person's forced (respiratory) expiratory volume for one (1) liter, or the arterial oxygen tension is less than sixty (60) MM/HG on room air at rest, or
- ☐ D. Must use portable oxygen, or
- ☐ 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
- ☐ F. Is severely limited in his or her ability to walk due to an arthritic, neurological, or orthopedic condition, or
- ☐ G. Is certified legally blind, or
- ☐ 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 Diagnosis: _____

TYPE OF PLACARD REQUESTED: ☐ 5 YR. PLACARD
☐ TEMPORARY PLACARD (issued for up to 6 months)

EXPIRATION DATE: _____

I certify that the applicant's physical disability described above is accurate and the care and treatment 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) (Zip)

PHONE: _____ PHYSICIAN'S SIGNATURE: _____

FOR OSAGE TAX COMMISSION ONLY

Expiration Date: _____ Date Issued: _____ Placard Number: _____

Mail this completed Application with \$10 check to:

If you have any questions, please call (918) 287-5393

Osage Nation Tax Commission
627 Grandview Ave
Pawhuska, OK 74056