Town of Southeast
Town Clerk Office
1360 Route 22
Brewster, NY 10509

HANDICAP PARKING APPLICATION

Part 1 - To be completed by the Handicapped applicant or guardian on behalf of a handicapped child.

Eligibility Requirements:

1. Must be a New York Resident
2. Severly disabled with a qualifying mobility impairment. (temporary or permanent)

Handicapped Applicant

Last | **First** | **Initial**

Area Code | **Telephone Number** | Sex | Date of Birth (mm,dd,yyyy)

Mailing Address: (no P.O. Boxes allowed, must be a physical address)

Number | **Street or Road Name**

City | **State** | **Zip Code**

County | **Town, City of Village**

I ❑ **do** ❑ **do not** have license plates for people with disabilities.

If you do, please supply license plate # _____

I certify that the information above is true and that I have read and understand the conditiions of this application and will comply with them.

_____
Signature of Applicant or Guardian

If signed by a guardian, what is your relationship to the applicant.

Below this Line - Town Clerk Office Only

❑ **Approved** ❑ **Denied**

TYPE OF LICENSE

❑ Perminant

❑ Temporary Expiration Date: _____

Permit number : _____

Reason: _____

Drivers License Identification

Drivers License Number

Issued | Expire Date

_____
Clerk's Signature | Date

Town of Southeast

Handicap Permit - Medical Certification

This form must be fully completed in order to be submitted as certification.

Patient Name - Please Print

Professional License Number

Physician/Podiatrist Name - Please Print

Telephone Number

Physician/Podiatrist Address, City, State, Zip Code - Please Print

One of the following three situations must be chosen.

1 ❑ **** PHYSICIAN - PLEASE BE SPECIFIC ABOUT PERMANENT CONDITION

A **"SEVERELY DISABLE PERSON"** is any person with any one of the following; mobility impairments, disabilities or conditions.

- ❑ has limited or no use of one or both legs
- ❑ has a neuro-muscular condition that severely limits mobility
- ❑ has other physical or mental condition not included above, which constitutes an equal degree of disability. This disability prevents the person from getting around without great difficulty.
- ❑ is legally blind

2 ❑ **** PERMANENT (3 Years) - The following explanation must be specific:

Please write legibly and specify how the applicant's disability limits or impairs his/her ability to walk. Specify any aids to walking that you have prescribed, please explain why the applicants impairment is PERMENANT. Explain how the patient's mobility impairment is similar to the one of the other qualifying disabilities, and specify what the comparable disability is.

3 ❑ **** Temporary Disability - The following explanation must be specific:

If the applicant impairment is temporary and he/she is unable to ambulate without the aid of an assisting device, please CHECK AND GIVE THE EXPECTED RECOVERY DATE.

Recovery Date

I hereby certify the above information.

Physician/Podiatrist Signature

Date