Side A

CARD NO
EXPIRATION DATE

Village of Skokie

HUMAN SERVICES DIVISION
5120 Galitz Street, Skokie, IL 60077
Phone (847) 933-8208
Fax (847) 677-0194

APPLICATION FOR DISABILITY PARKING PLACARD FOR TEMPORARY DISABILITY

DIRECTIONS: Both sides of this document must be signed and completed—Side A by the applicant and Side B by the physician.

PLEASE PRINT OR TYPE BELOW:

Name of Person with Disability(ies)

_____

Address | City | Zip

_____

Driver's License # or State ID # | Telephone

_____

Please provide the following information for the primary vehicle(s) used to transport the above individual:

Vehicle 1: Plate # _____ Make _____ Model _____ Color _____

Vehicle 2: Plate # _____ Make _____ Model _____ Color _____

PART 1. PERSON WITH DISABILITY

I hereby apply for a disability parking placard and certify that my physical condition entitles me to the issuance thereof. I am also aware that the disability parking placard must not be used unless I am a passenger in the vehicle.

_____ _____

Date Signature of Applicant

PART 2. FAMILY MEMBER

I hereby apply for a disability parking placard on behalf of the above-named individual and certify that the physical condition of this person entitles him/her to issuance thereof. I am also aware that the disability parking placard must not be used unless this individual is in the vehicle and that use of the placard when not transporting the person is considered abuse of the program and will result in immediate revocation of the placard. Further, I understand that the violator is subject to a penalty pursuant to Section 2-1093 of the Skokie Village Code.

_____ _____

Date Signature of Family Member

Family Member's Name | Telephone (include area code)

_____ _____

Address | City | Zip

_____

Relationship of family member to person with disability

_____

Side B
(To be completed by physician)

Persons with Disabilities Certification for Temporary Parking Placard

DIRECTIONS: Both sides of this document must be signed and completed. Side A must be completed by the applicant and Side B must be completed by the physician.

DEFINITION: "PERSONS WITH DISABILITIES" (625 ILCS 5/1-159.1)
"A natural person who, as determined by a licensed physician: (1) cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device; (2) is restricted by lung disease to such an extent that his or her forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 mm/hg on room air at rest; (3) uses portable oxygen; (4) has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV, according to the standards set by the American Heart Association; or (5) is severely limited in the person's ability to walk due to an arthritic, neurological, or orthopedic condition; or (6) cannot walk 200 feet without stopping to rest because of one of the above 5 conditions; or (7) is missing a hand or arm or has permanently lost the use of a hand or arm."

Please fill in the name of the person with the disability, state the diagnosis, and indicate the impairments below.

Name of Person with Disabilities: _____

Diagnosis: _____

NOTE: "Cannot walk 200 feet without stopping to rest" is no longer a qualifying disability unless it is related to one of the following conditions below.

☐ Is restricted by lung disease to such a degree that the person's forced (respiratory) expiratory volume (FEV) in one second, when measured by spirometry, is less than one liter.
☐ Uses portable oxygen
☐ Has a Class III or Class IV cardiac condition according to the standards set by the American Heart Association.
☐ Cannot walk without the assistance of another person, prosthetic device, wheelchair or other assistive device.
☐ Is severely limited in the person's ability to walk due to an arthritic, neurological or orthopedic condition.
☐ Has permanently lost the use of or is missing a hand or arm.

LENGTH OF DISABILITY: (Check One) ☐ 30 days ☐ 60 days ☐ 90 days*
*If the temporary condition will last more than 90 days, a new application must be submitted for additional days.

I hereby certify that the physical condition of the person with disabilities listed herewith constitutes him/her as a person with disabilities as described under 625 ILCS 5/1-159.1. **WARNING:** Any person who knowingly misuses or makes a false or misleading statement on an application may be fined up to $1,000. **PHYSICIANS: Do not sign this form if the patient does not meet the above definition.** (NOTE: If certification form is signed by a licensed physician assistant or advance practice nurse, the name and license number of the supervising physician is required.)

_____ _____
Physician's Signature Date Physician's License Number

_____ _____
Supervising Physician's Name Date Supervising Physician's License Number

PLEASE PRINT OR TYPE BELOW:
Physician's Name _____ Telephone ( ) _____

Address _____
Number and Street Name City Zip Code

**************************************For Office Use Only**************************************

DATE SUBMITTED _____ DATE ISSUED _____ ISSUED BY _____

Proof of Residency _____ Department _____

DENIED BY _____ Reason for Denial _____