NEW YORK CITY DEPARTMENT OF TRANSPORTATION
PARKING PERMITS FOR PEOPLE WITH DISABILITIES (PPPD)
APPLICATION FOR A **CITY** DISABILITY PARKING PERMIT

Please attach a copy of your State Issued Drivers License or Non Drivers Identification card

A. PERSONAL HISTORY OF APPLICANT (the person with the disability)			**Drivers License #**		**Non-Drivers ID #**
Last Name	First Name		M. Initial	Social Security # (Required)	
Home Address: Street & Apt. No.					
City	State	Zip Code	Phone No.	Work/Alternate No.	
Date of Birth	Sex (circle) M F	Height	Weight	Color Hair	Eye Color

B. Do you currently have a NY State permit? (blue hang tag) Yes___ No___
If no, and you are a New York City resident, would you like to apply for a State permit in addition to a City permit? Yes___ No___

C. LICENSE PLATE(S)
You must submit a copy of all current registrations. Please be advised registration(s) you submit to our office will be checked with the Parking Violations Operations unit, any plate(s) with outstanding judgment(s) will not be printed on your permit. *If you list more than 3 plate #'s you will not be able to get any temporary plate changes.

1.	3.	5	7.	9.
2.	4.	6.	8.	10.

D. DECLARATION
I declare, under penalties of the penal law § 210.45, that statements contained herein are, to the best of my knowledge and belief, true and correct and that I have not knowingly and willfully made a false statement or given information which I know to be false. I understand that any information given here will be shared only with those involved in the permit process, to the extent permitted or required by law.

_____ _____
DATE SIGNATURE OF APPLICANT*
If you will require the services of an interpreter at your medical assessment, please specify here which language (including sign language) you will need:
_____.

E. * If applicant is under 18 years old, or is unable to sign the application, please provide Name, and Telephone number of Parent, Guardian, Spouse or Contact.

Name _____Telephone _____Relationship_____

In addition to having your “personal” physician complete the application form, you must have your disability certified by a “City” physician designated by the New York City Department of Health and Mental Hygiene (DOHMH).

I want to be seen at a DOHMH Clinic. I prefer to be seen in:

Manhattan _____, Queens_____,

F. MEDICAL HISTORY AND STATUS of _____

Name **Date of Birth**

(*YOUR PERSONAL PHYSICIAN* MUST *COMPLETE THIS SECTION)*:

State nature and duration of disability. Give all diagnoses and **fully describe the primary mobility impairment problem. (PLEASE WRITE CLEARLY)**

Explain how severely the condition affects the ability to walk:

Date of last examination:

Is the disability permanent?
Yes ☐ No ☐

In your opinion, does this person have a disability that *requires* him or her to use a private automobile for transportation?
Yes ☐ No ☐

Please provide your patient with any necessary supporting medical documentation (e.g. X-Ray/CT/MRI Reports, EKG/Stress Test results, Surgical Summaries, etc.) to submit with this application for review by the City designated certifying physician to substantiate the applicant's mobility impairment. A review of the application and supporting documentation will be performed, and if needed, an in person assessment will be scheduled. If the in person assessment is not deemed necessary, a determination based on review of the application and supporting documentation will be made by the City designated physician. It is important that you accurately and thoroughly complete the information on this page.

Personal Physician's Certification of the Applicant:
I affirm that I have personally examined the above named applicant and that the information presented in this application relating to this person's disability is accurate. By signing below you are certifying that the information you are providing is true and complete, any false statements or deliberate misinformation are punishable under section 210.45 as per the NYS Penal Law; including fines. In addition, any false statements on your behalf will be reported to the NYS Department of Health Office of Professional Medical Conduct.

_____	_____	_____
SIGNATURE OF PHYSICIAN	NAME OF PHYSICIAN (PLEASE PRINT)	NYS PROFESSIONAL LICENSE #
_____	_____	_____
DATE	ADDRESS	TELEPHONE NO.