

Disabled Parking Application for Individuals

Once you and your healthcare provider have completed the appropriate sections, take this application AND A SEPARATE signed authorization from your healthcare provider to any vehicle licensing office or mail to: Special Plate Unit, Department of Licensing, PO Box 9043, Olympia, WA 98507.

Special Plate Ŭnit, D Applicant	epartment of Licensing, PO Box 9	0043,	Olympia, WA 98507.	J		
PRINT or TYPE Name (Last, First, Middle initial)					Date of birth (mm/dd/yyyy)	
Mailing address (PO Box or street address and apartment number, if applicab			(e) City		State	ZIP code
10-digit daytime phone	Email	Curre	nt license plate, if applicable	Registrat	tion expi	ration, if applicable
	X					
Parking privilege	options		horized representative signatu			
 Temporary placare application is require Permanent disable 	tre provider will determine if you g d–valid for 1 year or less. Only one p red to renew. ed parking–valid for 5 years. You m or tabs. Before your privilege expires,	placar lust be	d will be issued (no fe the registered owner	e requir of the v	ed). Å vehicle	new
□ Placard only – r Number of place □ Permanent plate Select one: □ 1 □ Disabled parkin Select one: □ 1 □ Disabled parkin	king choices (choose only one) no fee required ards: □ 1 □ 2 es–fee required (see dol.wa.gov for 1 placard and 1 set of license plates g tab for specialty or personalized pl 1 disabled parking tab □ 1 placard g tab for WATV–fee required (see delated)	☐ 1 lates- and 1 <u>ol.wa.</u>	set of license plates fee required (see dol. disabled parking tab gov for current fees)	wa.gov	for cu	rrent fees)
law enforcement, if as	entification (ID) card 2 to 4 weeks aft ked. ler –Doctor, physician, or licensed re		. , ,		•	·
You must provide a secondition which qualified or your office letterhea	separate signed authorization stat ies them for disabled parking priviled ad. If this application is printed on pro- nents. Return this form and your sign	ting: (′ ges. T escrip	 the applicant's name his authorization must tion paper, it meets bo 	e and (2 be on p oth the a	2) they prescri	have a iption paper
PRINT or TYPE Name		Profe	ssional classification	Pro	fessiona	l license number
Office address (Street address, City, State, ZIP code)				10-0	10-digit phone number	
Privilege duration Permanent Te	emporary for: months (up to 1	12 mc	nths)			
Answer the following My patient meets one of the following qualifying conditions: Cannot walk 200 feet without stopping to rest or must use assistive device Walking severely limited due to arthritic, neurological, or orthopedic condition Uses portable oxygen or walking restricted by lung disease Acute sensitivity to auto emissions that limits ability to wal Legally blind with limited mobility Restricted by porphyria (applicant benefits from a decreas in exposure to light)						
	lty of perjury under the law of Washinely affects mobility or involves acute s			ied abo	ve has	s a medical

A parking permit for a person with disabilities may be issued only for a medical necessity that severely affects mobility or involves acute sensitivity to light (RCW 46.19.010). An applicant or healthcare practitioner who knowingly provides false information on this application is guilty of a gross misdemeanor. The penalty is up to 364 days in jail and a fine of up to \$5,000 or both. In addition, the healthcare practitioner may be subject to sanctions under chapter 18.130 RCW, the Uniform Disciplinary Act.

MD, DO, DC, DPM, ND, ARNP, or PA ONLY signature

Date and place (city or county) signed