



Persons with Disabilities Certification for Parking Placard

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

DEFINITION: "PERSONS WITH DISABILITIES" (625ILCS 51-159.1)

"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 standards set by the American Heart Association; (5) is severely limited in the person's ability to walk due to an arthritic, neurological, or orthopedic condition; (6) cannot walk 200 feet without stopping to rest because of one of the above 5 conditions."

(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 a 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.

(Not to exceed 3 months) Condition is temporary – expected duration (in months) _____

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 can be fined up to \$1,000. PHYSICIANS: Do not sign this form if the name patient does not meet the above definition.**

Physician's Signature

Physician's License Number

PLEASE PRINT OR TYPE BELOW:

Physician's Name _____

Address _____

City _____ State _____ ZIP _____

Telephone(____) _____

GLENVIEW POLICE DEPARTMENT

SIDE B

(To be completed by applicant)

DIRECTIONS: Both sides of this document must be signed and completed in its entirety in order for the application to be processed. Complete Part 1, if the person with disabilities is applying for the placard. Complete Parts 1 and 2, if the form is being completed by someone other than the applicant.

PART 1. PERSON WITH DISABILITIES

I hereby apply for a Persons with Disabilities Placard

Under the statutory provision, (625 ILCS 5/1-159.1) and certify that my physical condition entitles me to the issuance thereof. I am also aware that the person with disabilities parking placard must not be used unless I am the driver or passenger in the vehicle.

_____ Date

_____ Applicant's Signature

WARNING: MISUSE OF OR FALSE APPLICATION FOR THE PERSON WITH DISABILITIES PARKING DEVICE can result in its revocation, a 30-day driver's license suspension, and a fine up to \$1,000. The person with disabilities must exit or enter the vehicle when parking in areas reserved for such person nor when parking at metered spots.

PLEASE PRINT OR TYPE BELOW:

Name of Individual with Disability	_____ OR _____ Male Female	Date of Birth (Month/Day/Year)
Address	City	Zip
Driver's License # OR Card Number of Individual with Disability		Telephone ()

PART 2. IF THIS FORM IS BEING COMPLETED BY SOMEONE OTHER THAN THE APPLICANT, PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOURSELF.

Name	Date
Address City	ZIP
Relationship to person with disabilities	Telephone ()

THIS PLACARD EXPIRES ON THE LAST DATE OF THE MONTH INDICATED BY THE HOLE PUNCH. ALL CARDS MUST BE RETURNED TO THE GLENVIEW POLICE DEPARTMENT UPON EXPIRATION.

..... **FOR OFFICE USE ONLY.**

Placard number _____ Exp. _____ Issued by _____ Date _____