

DISABILITY AND OXYGEN EMBLEM APPLICATION



Phone: 609.324.3560
 Fax: 609.324.8493

A. Application: New
 Update

B. Name of Applicant (Last, First, Middle Initial)

 Applicant's Mailing Address: _____

 Applicant's Telephone: _____
 Applicant's Birth Date: _____

C. Name of Co-Applicant (Last, First, Middle Initial)

 Co-Applicant's Mailing Address: _____

 Co-Applicant's Telephone: _____
 Co-Applicant's Birth Date: _____

FOR OFFICIAL USE ONLY

Accepted Muni Code: _____
 Rejected

APPLICANT PHYSICIAN INFORMATION

1. Name of Physician (Last, First, Middle Initial)

 2. Physician's Mailing Address: _____

 3. Physician's Telephone: _____
 4. Physician's Signature & Date:

TYPE OF EMBLEM REQUESTED

5" Inside Glass Mount 7" Inside Glass Mount
 5" Outside Mount 7" Outside Mount

APPLICANT MEDICAL INFORMATION

Does Applicant Have a Current Handicapped Parking Placard?
 Yes Expiration Date: _____
 No Please check below which best describes disability.

Severely or permanently disabled
 Must use device for assistance (please check which device)

- Cane
- Crutch
- Wheelchair
- Prosthetic Device
- Other person
- Other (Explain) _____

Lung Disease
 Cardiac Condition with class III limitation *
 Cardiac Condition with class IV limitations*
 Deaf
 Hard of Hearing
 Permanent Sight impairment **

* As defined by the American Heart Association
 ** As defined by the New Jersey Commission for the blind

Ability to walk is severely limited to:
 Arthritic Condition
 Neurological Condition
 Orthopedic Condition

Oxygen (Tank or Oxygen Delivery System)

APPLICATION MUST BE REVIEWED EVERY TWO YEARS

Applicant's Signature & Date:

Co-Applicant's Signature & Date:
