



For Office Use Only:
Permit # _____

TOWN OF SHELTER ISLAND

38 North Ferry Road – P.O. Box 1549
Shelter Island, New York 11964

SHELBY MUNDY
TOWN CLERK
REGISTRAR OF VITAL STATISTICS
FREEDOM OF INFORMATION OFFICE
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FAX NUMBER (631) 749-3436
townclerk@shelterislandtown.gov
<https://www.shelterislandtown.gov>

HANDICAPPED PARKING PERMIT APPLICATION

Part I. This page is to be completed by the handicapped applicant, or the parent or guardian on behalf of a handicapped child.

Name of Handicapped Person

Last

First

Residence & Mailing Address

Street and P.O. Box

Town

State

Zip Code

Date of Birth _____ Sex: ___M___F Telephone _____

Last Three Digits of Applicant's Driver's License, if applicable: _____

I certify that the statements contained herein are true. I further acknowledge that I have read and understand the conditions of this application and the Handicapped Parking Permit, and shall observe and comply with same. Attached to this application is certification or prescription by a physician licensed to practice in the State of New York.

Date: _____

Signature of Applicant or Parent/Guardian



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Part II. This part is to be completed by the certifying physician.
MEDICAL CERTIFICATION

Name of Physician _____ License No. _____
Address _____ Telephone _____

Name of Handicapped Person _____

TEMPORARY DISABILITY: Any person who is temporarily unable to ambulate without the aid of an assisting device, including but not limited to, a brace, cane, crutch, prosthetic device, another person, wheelchair or walker. **IMPORTANT:** Temporary Permits are issued for six months or less regardless of expected recovery date.

Diagnosis: _____ **Expected Recovery Date:** _____

What assistive device is needed? _____

PERMANENT DISABILITY: A "severely disabled" person is any person with one or more of the PERMANENT impairments, disabilities, or conditions listed below, which limit mobility.

Diagnosis: _____ **Please check the conditions that apply:**

- Uses portable oxygen
- Legally blind
- Limited or no use of one or both legs
- Unable to walk 200 feet without stopping
- Neuromuscular dysfunction that severely limits mobility
- Class III or IV cardiac condition (American Heart Association standards)
- Severely limited in ability to walk due to arthritic, neurological or orthopedic condition
- Restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg of room air at rest
- Has a physical or mental impairment or condition not listed above which constitutes an equal degree of disability, and which imposes unusual hardship in the use of public transportation and prevents the person from getting around without great difficulty.

EXPLAIN BELOW HOW THIS DISABILITY LIMITS FUNCTIONAL MOBILITY:

Signature of Physician: _____ Date: _____

