

Persons with Disabilities Certification for Parking Placard

DIRECTIONS: Both sides of this document must be signed and completed; the front side by a licensed physician and the back side by the applicant.

DEFINITION: "PERSON WITH DISABILITIES" (625 ILCS 5/1-159.1)

"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 60mm/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 standard set by the American Heart Association; or (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 five 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 Class IV cardiac condition according to the standards set by the American Heart Association.
___ Cannot walk without 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.

LENGTH OF DISABILITY ___ Temporary*

* May not be issued for more than 90 days

I hereby certify that the physical condition of the person with disabilities listed herewith constitutes him/her as a disabled person as described under 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 named patient does not meet the above definition.

Physician's Stamp/License Number Required

Physician's Name _____

Physician's Signature _____

Address _____

Physician's License Number _____

City _____ ZIP _____

(_____) _____

Telephone _____

