



# Ottawa Tribe of Oklahoma

## Disability Tag Application

This form must be completed by applicant and physician before a disability tag can be issued.

**Only One tag per Disabled Person /a one-time ten (10.00) fee is required**

I hereby make application to the Ottawa Tribe of Oklahoma for a disability parking tag.

Applicant (patient) name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Mailing address: \_\_\_\_\_

(Street or P.O. box) (City) (State) (Zip)

Driver license/ID number: \_\_\_\_\_

Phone: \_\_\_\_\_ (Home)

Signature (required): \_\_\_\_\_

**If you all ready have an Oklahoma Disability placard Please bring in the proof that it is yours and then you do not have to have a doctor fill out the rest of the form.**

***The following section must be completed by a physician licensed to practice medicine or surgery, osteopathic medicine, chiropractic, podiatric medicine, or optometry; a licensed physician assistant; or a licensed and certified advanced registered nurse practioner. The above-named applicant (patient):***

- a. Is certified legally blind,
- b. Is restricted to such an extent that the person's forced (respiratory) expiratory volume for one liter, or the arterial oxygen tension is less than 60MM/HG on room air at rest
- c. Must use portable oxygen,
- d. Is missing one or more limbs which impair mobility.
- e. Cannot walk 200 feet without stopping to rest
- f. Has functional limitations which are classified in severity as Class III or Class IV according to standards set by the American Heart Association
- g. Is severely limited in his or her ability to walk due to an arthritic neurological, or orthopedic condition
- h. Cannot walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistant device.

***In your professional opinion would this condition affect this person's ability to safely operate a motor vehicle under normal or adverse driving conditions?***  No  Yes Diagnosis: \_\_\_\_\_

**Type of Tag requested: 1 year** \_\_\_\_\_ **Permanent** \_\_\_\_\_ I certify that the applicant's (patient's) physical disability described above is accurate, and the care and treatment is within the authorized scope of my practice.

Date: \_\_\_\_\_ Physician's name: \_\_\_\_\_ Physician's license no. \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician's signature: \_\_\_\_\_