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: _____