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| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **SECTION 1: APPLICANT INFORMATION** *(to be completed by applicant before submitting to a physician)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Issuance**   **2nd Placard**   **Renewal**  **Replacement** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **NAME** (*individual or organization)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **DATE OF BIRTH** | | | | | | | | | | | | | | | | | **PHONE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **ADDRESS** (*street or post office*) | | | | | | | | | | | | | | | | | | | | | | **CITY** | | | | | | | | | | | | | | | | | | | | **STATE** | | | | | | | | | | | | | | | | | **ZIP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Check all that apply:** | | | | | | | | | | |  | | |  | |  | |  | | | |  |  |  | | |  | | |  | | | |  | |  | | |  | |  | | | |  | | | |  | | |  | | | | |  | | | | |  | | |  | | | |  | | | | | | |  | | | | | |  | | | | | | | | |  | | | |  | | | | Parking Placard or  Disabled License Plate | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |  | | | |  | |  | | |  | | |  | | | | |  | | |  | | |  | | | | |  |  | | | | | | | | | | |  | |  | | | | | |  | | | | |  | | | | | | | | | Applicant now holds disabled license plate or parking placard # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Applicant now holds disabled veteran license plate # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | |  | | | |  | |  | |  |  |  |  | |  | | | |  | |  | |  | |  |  |  | Attesting Official or Notary Signature & Title | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | |  | | | | **SECTION 2: LICENSED PHYSICIAN CERTIFICATION** *(not valid if Section 1 is incomplete)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | I certify that the applicant is a person who has a severe visual, audio, or physical impairment which limits or prevents  his or her ability to walk in compliance with KRS 186.042 or KRS 189.456, or KRS 189.458. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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| | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | |  | | | |  | *(Printed Name of Licensed Physician, Physician Assistant, Chiropractor, or Advanced Practice Registered Nurse)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | |  | | | | **Temporary Disabled Parking Placard (Red-3 months)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | |  | |  | | | | | |  | | |  | | |  | | | | | | | |  | | | | |  | | | | | | | | | |  | | | |  | | | |  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | (*Signature of Licensed Physician, Physician Assistant, Physical Therapist, Occupational Therapist, Chiropractor, or Advanced Practice Registered Nurse*) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | (*Date*) | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | *(Printed Name of Licensed Physician, Physician Assistant, Physical Therapist, Occupational Therapist, Chiropractor, or Advanced Practice Registered Nurse*) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | **FOR COUNTY CLERK’S USE ONLY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | I hereby attest that the applicant is obviously disabled in compliance with KRS 186.042 and KRS 189.456 and should be issued a special parking permit. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | Signature of Clerk | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | County | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | |  | | | | Previous Placard #: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Expires | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | |  | | | | New Placard #: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Expires | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | |  | | | | Replacement Reason: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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