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| --- |
| **INSTRUCTIONS:** Complete this form and forward to your County Clerk. |
| **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 # |       |  |
|  |  |  |  |       |  |  |  |
|  | *(Signature of Applicant)* |  |  | *(FED ID/SSN/DLN)* |  |  |  |
|  | Subscribed and attested before me this date |  |    | / |    | / |      | . | My commission expires |    | / |    | / |      | . |  |  |
| MM | DD | YYYY |  |  | MM | DD | YYYY |  |
|  | My commission #: |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  | 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. |  |  |
|  |  |  |
| [ ]  **Disabled Parking Placard (Blue-6 years)** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | (*Signature of Licensed Physician, Physician Assistant, Chiropractor, or Advanced Practice Registered Nurse*) |  |  | (*Date*) |  |  |  |
|  | *(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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