



# Kenilworth Police Department

Side B  
(To be completed by applicant)

**DIRECTIONS:** Both sides of this document must be signed and completed in its entirety in order for the application to be processed. Complete part 1, if the person with disabilities is applying for a parking placard. Complete parts 1 and 2, if member of the person with disabilities immediate family is applying for a parking placard.

## PART 1. PERSON WITH DISABILITIES

I hereby apply for:

\_\_\_\_\_ Person with Disabilities Parking Placard

Under the statutory provision, (625 ILCS 5/1-159.1) and certify that my physical condition entitles me to the issuance thereof. I am also aware that the person with the disabilities parking device must not be used unless I am a passenger in the vehicle.

\_\_\_\_\_ Date

\_\_\_\_\_ Applicant's Signature

### PLEASE PRINT OR TYPE BELOW:

Applicant's Name		Address	
City	ZIP	Telephone	
Drivers License # or State ID		Social Security	
<b>Please provide the following information for the primary vehicle(s) used to transport the applicant:</b>			
Vehicle 1: Vehicle Identification # _____		Plate # _____	
Vehicle 2: Vehicle Identification # _____		Plate # _____	

## PART 2: FAMILY MEMBER

Family Members Name	Date
Address	City / ZIP
Relationship of member to person with disabilities	Telephone

### FOR OFFICE USE ONLY

-----

1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ Expiration Date \_\_\_\_\_

Issued by \_\_\_\_\_ Issue Date \_\_\_\_\_

**PLACARDS MAY ONLY BE ISSUED FOR A MAXIMUM OF 90 DAYS**

**WARNING: MISUSE OF OR FALSE APPLICATION FOR THE PERSONS WITH DISABILITIES PARKING DEVICE can result in its revocation, a 30-day driver's license suspension, and a fine up to \$1,000.00. The person with disabilities must be present when parking the vehicle in areas reserved for such person or for free at metered spots.**



# Kenilworth Police Department

## Persons with Disabilities Certification for Parking Placard

**DIRECTIONS:** Both sides of this document must be completed, side A by the physician and side B by the applicant.

**DEFINITION:** "PERSONS 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 arterial oxygen tension is less than 60 mm/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 standards 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 5 conditions."

(Please fill in applicant's name, describe the condition, and indicate the impairments below.)

Person with Disabilities Name \_\_\_\_\_

Condition \_\_\_\_\_

**\*\*\*\*\*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.\*\*\*\*\***

- \_\_\_\_\_ Cannot walk without the assistance of another person, prosthetic device, wheelchair, or other assistive device.
- \_\_\_\_\_ 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.
- \_\_\_\_\_ Is severely limited in the person's ability to walk due to an arthritic, neurological, or orthopedic condition.

**LENGTH OF DISABILITY:**

**(Not to exceed 3 months)**

Expected Duration (*in months*): \_\_\_\_\_

I hereby certify that the physical condition of the person with disabilities listed herewith constitutes him/her as a person with disabilities as described under 625 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 signature

\_\_\_\_\_  
Physician's license number

PLEASE PRINT OR TYPE BELOW:

Physician's Name: \_\_\_\_\_

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

City / State: \_\_\_\_\_

ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_