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KENTUCKY TRANSPORTATION CABINET  
Division of Motor Vehicle Licensing  
P.O. Box 2014  
Frankfort, Kentucky 40602-2014

TC 96-204  
Rev. 10/96

APPLICATION FOR DISABLED PERSONS SPECIAL PARKING PERMIT

**SECTION 1 – TO BE COMPLETED BY APPLICANT**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(Street or Post Office Box) (City) (State) (Zip Code)

- CHECK ONE:
- Applicant now holds disabled parking license No. **HP** \_\_\_\_\_
  - Applicant now holds disabled veteran license No. **HV** \_\_\_\_\_
  - County Clerk attests that applicant is obviously disabled in Section 2 below.
  - A licensed physician signs statement that applicant is disabled in Section 3 below.

\_\_\_\_\_  
(Signature of Applicant) (Social Security Number)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_  
My Commission expires \_\_\_\_\_, 20\_\_\_\_\_  
(Signature of Person Attesting Oath)

**SECTION 2 – TO BE COMPLETED BY COUNTY CLERK**

I hereby attest that the applicant is obviously disabled and should be issued a special parking permit.

Signature of Clerk \_\_\_\_\_ County \_\_\_\_\_

**SECTION 3 – TO BE COMPLETED BY A LICENSED PHYSICIAN**

I certify that the applicant is a person whose mobility, flexibility, coordination, respiration, or perceptiveness is significantly reduced by disability to that person's arms, legs, lungs, heart, ears, or eyes.

- CHECK ONE: This is a
- Permanent Disability
  - Temporary Disability

Signature of Licensed Physician \_\_\_\_\_

Printed Name of Physician \_\_\_\_\_ (or) License # \_\_\_\_\_

**COUNTY CLERK'S USE ONLY**

Previous Placard # \_\_\_\_\_ Expires \_\_\_\_\_

New Placard # \_\_\_\_\_ Expires \_\_\_\_\_

Replacement Reason: \_\_\_\_\_