Minnesota Department of Public Safety
Driver and Vehicle Services
445 Minnesota St. | Suite 164 | St. Paul, MN 55101
drive.mn.gov

Application for disability parking certificate

Submit the completed form in person at any deputy registrar office or mail to the address above. Visit our website for office locations.

Note: Incomplete or missing information will cause significant delays in issuance.

Part A: Person with a disability

To be completed by, or on behalf of, the disability parking certificate applicant.

First, middle and last name _____

Address _____ Phone _____

City, state and ZIP code _____

Minnesota driver's license or ID number _____ Date of birth _____

If no Minnesota license or ID, explain _____

Non-residents may apply for a temporary disability parking certificate or use the parking certificate issued by their state of residence.

Certificate request

Is this application for two parking certificates? Note: Two certificates are not an option if applicant has disability license plates. ☐ Yes ☐ No

If applying for replacement, check reason: ☐ Lost ☐ Stolen ☐ Damaged ☐ Other _____

What is the certificate number still in possession? _____

Tennessen notice

The following notice is provided pursuant to Minnesota Statutes section 13.04, subd. 2. The Department of Public Safety's and Driver Vehicle Services DVS collects the information requested on this form to determine eligibility for a disability parking certificate, administer the disability parking certificate program, maintain required records, and carry out other duties authorized by law. You are not legally required to complete this form. You can refuse, however; DVS may consider your application incomplete and not issue a disability certificate. The information you provide may be disclosed to persons or entities authorized to receive it, including law enforcement agencies, courts, and other

government entities as authorized by the Minnesota Government Data Practices Act, the Driver's Privacy Protection Act, and other applicable laws.

I hereby certify the above information is complete and accurate to the best of my knowledge. I also give permission to the health professional to supply the information requested.

Applicant name _____ Date of birth _____

Name of parent or guardian (if signing on behalf of applicant) _____

Relationship to applicant _____

Signature of applicant or parent/guardian _____ Date _____

Part B: Health professional completes this section

To be completed by a licensed physician, physician assistant, advanced practice registered nurse, chiropractor or physical therapist.

Notice regarding qualification to drive

Complete the Request for examination of driver (PS31924) if:

- Your patient requires adaptive equipment to safely operate a motor vehicle.
- You have concerns your patient is not medically qualified to exercise reasonable and ordinary control over a motor vehicle.
    - If you are a physician reporting in good faith and exercising due care, you are immune from liability.

We will require the person reported to complete an examination to keep their driving privileges.

Medical statement

All questions in this section must be answered for the application to be accepted.

Your patient must meet one or more of the definitions described below. Be sure to specify the diagnosis of the condition causing the disability when requested below.

The patient (select at least one)

☐ 1. Has a cardiac condition to the extent that the applicant's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association.

☐ 2. Uses portable oxygen.

☐ 3. Has an arterial oxygen tension (PAO_2) of less than 60 mm/Hg on room air at rest.

☐ 4. Is restricted by a respiratory disease to such an extent that the patient's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter.

Applicant name _____ Date of birth _____

☐ 5. Has lost an arm or leg and does not have or cannot use an artificial limb.

☐ 6. Is legally blind.

☐ 7. Uses a wheelchair or cannot walk without the aid of another person, walker, cane, crutches, braces, prosthetic device or other assistive device. Specify device _____
Specify diagnosis of condition causing disability _____

☐ 8. Has a disability that would be aggravated by walking 200 feet under normal environmental conditions to an extent that would be life-threatening.
Specify diagnosis of condition causing disability _____

☐ 9. Cannot walk 200 feet without stopping to rest.
Specify diagnosis of condition causing disability _____

☐ 10. Cannot walk without a significant risk of falling.
Specify diagnosis of condition causing disability _____

Certificate type requested

☐ Temporary: 1-6 months, specify duration in months _____. Fee $5 each

☐ Short term: 7-12 months, specify duration in months _____. Fee $5 each

☐ Long term: 13-71 months, specify duration in months _____. No fee

☐ Permanent: 6 years. No fee

Health professional certification and signature

I understand that fraudulently certifying that a person is a physically disabled person and entitled to a disability certificate or plates is a crime under Minnesota Statutes section 169.345, subd. 2a.

Signature _____ Title _____

Printed name _____ Date _____

Phone _____ Address _____

City, state and ZIP code _____