

Persons with Disabilities Certification for Plates or Parking Placard

DIRECTIONS: Both sides of this document must be signed and completed. Side A must be completed by the physician. Side B must be completed 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 the 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; (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 the name of the person with the disability, state the diagnosis, and indicate the impairments below.)

Name of Person with Disabilities _____

Diagnosis _____

*******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.*******

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

LENGTH OF DISABILITY: Check one

- Disability is permanent
- Disability is temporary—**must state duration** (maximum 6 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. (NOTE: If certification form is signed by a Licensed Physician Assistant or Advance Practice Nurse, the name and license number of the Supervising Physician is required).**

Physician's signature

Physician's license number

Supervising Physician's name

License number

PLEASE PRINT OR TYPE BELOW:

Physician's Name _____

Address _____

City _____ State _____ ZIP _____

Telephone (____) _____

Please mail all required documentation to Secretary of State, Persons with Disabilities License Plate/Placard Unit, 501 South 2nd St., Room 541, Springfield, IL 62756.

