



TOWN OF ISLIP DEPARTMENT OF PARKS, RECREATION & CULTURAL AFFAIRS

50 IRISH LANE • EAST ISLIP, NEW YORK 11730-2098 • (631) 224-5335

Hearing Impaired (631)224-5397

Angie M. Carpenter, Supervisor
Thomas Owens, Commissioner

TEMPORARY AND PERMANENT PARKING PASS INSTRUCTIONS

1. Physician **MUST** complete the Medical Certification in its entirety, state if your disability is *permanent* or *temporary* and doctor's office stamp is required on the application. Physician **MUST** provide original signature. (**Signature stamps not accepted.**)
2. ***Temporary Parking Permits*** can **ONLY** be completed by a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) and **MUST** state what assistive device is needed.
3. ***Permanent Parking Permits*** can be completed by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), for disabilities of the foot- Doctor of Podiatric Medicine (DPM), or for blindness-Optometrist (OD). Any/all providers listed must be authorized by NYSVTL, section 404-A. Medical certification cannot be given by a chiropractor, physical therapist, or nurse.
4. **A copy of a valid NYS Driver's License/Non Driver's ID is required.** If the address is different or a P.O. Box, please provide official mail postmarked within the last six months, showing the current Town of Islip address (i.e. medical bill/explanation of benefits, PSEG, bank statement, credit card bill, car insurance or registration). If no valid NYS DL/Non DL, another photo ID is required along with current proof of address.
 - ***For minor or applicant over the age of 18 (incapable of signing on own behalf), proof of residency is required along with a copy of DL/Non DL and photo ID of the parent or guardian who has signed the application.***
 - ***P.O. Boxes are not proof of address***
5. ***Expired Parking Permits*** **MUST** be returned.
6. Applications may be mailed to: 50 Irish Lane, East Islip NY 11730 Attn: Disabled Parking Permits
7. **NO FAX OR PHOTOCOPIES OF THE APPLICATION WILL BE ACCEPTED.**

Special Notice & Caution: New York State Traffic Law states that this permit be used exclusively in a vehicle in which the person to whom it has been issued is being transported, and such permit shall not be transferable and shall be forfeited, if presented by any other person. Any abuse by any person, facility or agency to whom such a permit has been issued, shall be sufficient cause for revocation of said permit of any privilege, benefit, precedence or consideration granted pursuant to the issuance of such permit.

If your application is approved, you will receive a blue (permanent) or a red (temporary) plastic permit which is to be hung on your rear view mirror when parked. If you have any questions about the application, please call (631)224-5335 (voice) or (631) 224-5397 (Hearing Impaired), or you can visit us at 50 Irish Lane, East Islip, NY 11730.



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Name: _____ Date of Birth: _____ Sex: Male/Female
 Home Address: _____
 Mailing Address (if different from above): _____
 Home Phone: _____ Cell or Business Phone: _____

I certify that the above information and the statements contained herein are true. I further acknowledge that I have read and understood the conditions of the application and the disabled parking permit.
 X _____
 Signature of Person with Disability/Signature of Parent or Guardian (*Blue Ink Only*) _____ Date _____
If signed by a parent or guardian, please state your relationship to the person with the disability after your signature.

MEDICAL CERTIFICATION

Name of (MD/DO ONLY): _____ **Professional License #** _____
Diagnosis: _____

TEMPORARY DISABILITY: A person with a “temporary disability” is any person who is TEMPORARILY unable to ambulate without the aid of an assisting device. Examples of an assisting device include, but are not limited to, a leg/knee brace, cane, crutch, prosthetic device, another person, wheelchair or walker. **TEMPORARY DISABILITIES** may only be certified by a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO).
IMPORTANT: Temporary permits are issued for six months or less regardless of expected recovery date.

Expected Recovery Date: ____ / ____ / ____ What assistive device is needed? _____

Name of (MD/DO/DPM/NP/PA/OD ONLY): _____ **Professional License #** _____
Diagnosis: _____

PERMANENT DISABILITY: A “severely disabled” person is any person with one or more of the PERMANENT impairments, disabilities or conditions listed below, which limit mobility. **PERMANENT DISABILITIES** may be certified by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), a Doctor of Podiatric Medicine (DPM, for disabilities related to the foot) or Optometrist (OD, for blindness).

Neuromuscular dysfunction that severely limits mobility Class III or IV cardiac condition (American Heart Assoc. Standards) Legally blind
 Severely limited in ability to walk due to an arthritic, neurological or orthopedic condition Limited or no use of one or both legs
 Restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg of room air at rest Unable to walk 200 ft. without stopping
 Has a physical or mental impairment or condition not listed above which constitutes an equal degree of disability, and which imposes unusual hardship in the use of public transportation and prevents the person from getting around without great difficulty Uses portable oxygen

X _____
 Signature (*Blue Ink & Original Signature ONLY*) _____ Date _____

PLACE REQUIRED DOCTOR'S OFFICE STAMP HERE

For office use only: New/Temp Renewal/Temp to Perm/ Travel/Damaged Tag Code: _____
 Permit #: _____ Exp. Date: _____ Driver's License#: _____ Exp. Date: _____
 Prior #: _____ Returned: _____ Plate #: _____ BAS: _____