



**Instructions and Application  
New York City Special Vehicle Identification Parking Permit  
Parking Permit for People with Disabilities (PPPD)**

You can now apply On-Line for a New York City Disability Parking Permit, at the below web site address or mail your application in to our [ ~~31~~ ] at the below address.

The following requirements must be met by a person with a disability to qualify for a City Parking Permit for People with Disabilities (PPPD):

- I. **You must provide us with a valid copy of your Driver's License or Non-Driver's Identification card.**
- II. You must require the use of a private vehicle for transportation.
- III. You must have a severe, permanent disability that impairs mobility as certified by your personal physician and a New York City physician designated by the Department of Health at an assessment center.
- IV. Please provide all pertinent information requested on the application form. Write your name on the application **EXACTLY** as it appears on your State-issued Driver's License or Non Driver's Identification card. **Please attach a copy of your Driver's License or Non driver Identification card.** Incomplete applications will be returned. **PRINT OR TYPE** all information except for signatures.
- V. If you are unable to sign, or the applicant is a minor, then a parent, spouse, guardian, or person with power of attorney may sign, stating the reason and the relationship to you.
- VI. *Vehicle registrations must be current and valid. **We will not accept any plate number(s) in judgment with the New York City, Department of Finance Parking Violations Operations unit.***

NOTE: **One** permit with specified plates printed on it will be issued to the person with a disability who is certified by a physician designated by the NYC Department of Health. This permit holder **must move the permit** to whichever vehicle he or she is using at the time. **No copies** are allowed.



- VII. When we receive your application, we will review it for completeness. An incomplete application will be returned to you with a letter requesting the missing information. Complete applications will be forwarded within five working days to the Department of Health's assessment center you choose.
- VIII. Assessment center staff will contact you to schedule the required certification assessment appointment. If you are unable to make your scheduled appointment, you must call to cancel and reschedule no later than 48 hours before your appointment. *Note: Please plan to take any supporting medical documentation or reports **with you** to your appointment.*
- IX. If you are certified "approved" by the designated Department of Health City Physician, we will issue you a permit. If you are certified "denied," we will send you a denial-of-certification letter, which shall include a description of the appeal process.

NOTE: All information that you submit with this application and any subsequent medical information that you submit to the certifying physician will be kept confidential and will only be shared with those involved in the certification and/or permit process, to the extent permitted or required by law. If you have questions regarding this application, you may call PPPD at the following telephone numbers for assistance: (718) 433-3100 during business hours, Monday - Friday.

NYC Department of Transportation  
Parking Permits for People with Disabilities  
28-11 Queens Plaza North, 8th Floor  
Long Island City, NY 11101-4008

**Note to all applicants:**

1. You must send this completed application and required documents to PPPD, 28-11 Queens Plaza No, 8<sup>th</sup> Fl. Long Island City, NY 11101-4008
2. You must notify the Parking Permits for People with Disabilities (PPPD) Unit *in writing* of all changes of address.
3. Please call 718/433-3100 or TTY 212/504-4115 if you have any questions concerning your application.

[Click here](#) if you wish to obtain a voter registration form. Government services are not conditioned on being registered to vote. A voter registration form can also be obtained at <http://nyc.gov/html/misc/html/register.html>, or by calling (212) 868-3692.

NEW YORK CITY DEPARTMENT OF TRANSPORTATION  
 PARKING PERMITS FOR PEOPLE WITH DISABILITIES (PPPD)  
 APPLICATION FOR A **CITY** DISABILITY PARKING PERMIT

**Please attach a copy of your State Issued Drivers License or Non Drivers Identification card**

<b>A. PERSONAL HISTORY OF APPLICANT (the person with the disability)</b>			<b>Drivers License #</b>		<b>Non-Drivers ID #</b>	
Last Name		First Name		M. Initial	Social Security # (required)	
Home Address: Street & Apt. No.						
City		State	Zip Code	Phone No.		Work/Alternate No.
Date of Birth	Sex (circle) M      F		Height	Weight	Color Hair	Eye Color
<b>B. Do you currently have a NY State permit? (blue hang tag)</b>					Yes___ No___	
If no, and you are a New York City resident, would you like to apply for a State permit in addition to a City permit?					Yes___ No___	
<b>C. LICENSE PLATE(S)</b>						
You must submit a copy of <u>all</u> current registrations. Please be advised registration(s) you submit to our office will be checked with the Parking Violations Operations unit, any plate(s) with outstanding judgment(s) will not be printed on your permit. *If you list more than 3 plate #'s you will not be able to get any temporary plate changes.						
1.		3.		5.		9.
2.		4.		6.		10.
<b>D. DECLARATION</b>						
I declare, under penalties of the penal law § 210.45, that statements contained herein are, to the best of my knowledge and belief, true and correct and that I have not knowingly and willfully made a false statement or given information which I know to be false. I understand that any information given here will be shared only with those involved in the permit process, to the extent permitted or required by law.						
_____			_____			
DATE			SIGNATURE OF APPLICANT*			
If you will require the services of an interpreter at your medical assessment, please specify here which language (including sign language) you will need:						
_____.						
<b>E. * If applicant is under 18 years old, or is unable to sign the application, please provide Name, and Telephone number of Parent, Guardian, Spouse or Contact.</b>						
Name _____ Telephone _____ Relationship _____						

In addition to having your “personal” physician complete the application form, you must have your disability certified by a “City” physician designated by the New York City Department of Health (DOH).

I want to be seen at a DOH Clinic. I prefer to be seen in:

Manhattan\_\_\_\_\_, Brooklyn\_\_\_\_\_, Bronx\_\_\_\_\_, Queens\_\_\_\_\_, Staten Island\_\_\_\_\_.

MEDICAL HISTORY PAGE

F. MEDICAL HISTORY AND STATUS of \_\_\_\_\_  
Name Date of Birth

**(YOUR PERSONAL PHYSICIAN MUST COMPLETE THIS SECTION):**

State nature and duration of disability. Give all diagnoses and **fully describe the primary mobility impairment problem. (PLEASE WRITE CLEARLY)**

Etiology/Cause:

Date of last examination:

Is the disability permanent?

Yes  No

In your opinion, does this person have a disability that *requires* him or her to use a private automobile for transportation?

Yes  No

**Please provide your patient with any necessary supporting medical documentation (e.g. X-Ray/CT/MRI Reports, EKG/Stress Test results, Surgical Summaries, etc.) for the applicant to take with him or her to the assessment appointment with the city designated certifying physician to substantiate his or her mobility impairment.**

Personal Physician's Certification of the Applicant:

**I affirm that I have personally examined the above named applicant and that the information presented in this application relating to this person's disability is accurate.** By signing below you are certifying that the information you are providing is true and complete, any false statements or deliberate misinformation are punishable under section 210.45 as per the NYS Penal Law; including fines. In addition, any false statements on your behalf will be reported to the NYS Department of Health Office of Professional Medical Conduct.

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
NAME OF PHYSICIAN (PLEASE PRINT)

\_\_\_\_\_  
NYS PROFESSIONAL LICENSE #

\_\_\_\_\_  
DATE

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
TELEPHONE NO.

**NOTE TO THE PERSONAL PHYSICIAN:**

This form is being submitted for application to obtain a City disability parking permit. The applicant will also be assessed by a certifying physician designated by the NYC Department of Health (DOH) for assessment and review of this application. It is important that you accurately and thoroughly complete the information above.