Application for Disability Permit

To be completed by: Person with a Physical Disability

For Office Use Only

Full Name (please print)

Address

City/State/Zip Code

Daytime Phone Number

I am a resident of the State of Minnesota, I DO NOT operate a motor vehicle, and I DO NOT own or have a long term lease in a motor vehicle. I certify that the above statement is accurate to the best of my knowledge.

Signature Date

Do you possess a disability parking certificate issued by the state of Minnesota Department of Public Safety or a Federal Access Pass? Yes ◯ No ◯
If YES, please give certificate number and expiration date

Certificate Number Expiration Date

If NO, a physician/chiropractor must complete the back of this form.

I hereby request a disability permit for Minnesota State Parks for the calendar year _____.

Payment by Check:
I have enclosed a payment of $ _____ Check #: _____
Make checks payable to Department of Natural Resources

Payment by Credit Card:

☐ Visa ☐ Mastercard ☐ Discover

Card number Expiration Date

To receive your permit, return this form along with payment to:

Gooseberry Falls State Park
3206 Highway 61
Two Harbors, MN 55616

<u>Your Physician or Chiropractor must complete this portion of the application,</u> if you do not have a disability parking permit.

<u>Please note:</u> Failure to give complete and accurate information regarding the disability may result in cancellation of the application or may cause the applicant to receive a request for additional medical information.

To be eligible to purchase a special Minnesota State Park disability permit, the applicant must meet one or more of the definitions described below of a "physically disabled person".

Check which definition(s) the applicant meets.

- ☐ The applicant has a cardiac condition to the extent that the applicant's functional limitations are classified in severity class III or class IV according to the standards set by the American Heart Association.
- ☐ The applicant uses portable oxygen.
- ☐ The applicant has an arterial oxygen tension of less than 60 mm/Hg on room air at rest.
- ☐ The applicant is restricted by a respiratory disease to such an extent that the applicant's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter.
- ☐ Because of the disability, applicant cannot walk without the aid of another person, a walker, a cane, crutches, braces, a prosthetic device, or a wheel chair. (Please circle impairment)
- ☐ Because of disability applicant cannot walk 200 feet without stopping to rest.*
- ☐ Because of disability applicant cannot walk without a significant risk of falling.*
- ☐ The applicant has lost an arm or leg and does not have or cannot use an artificial limb.
- ☐ Because applicant has a condition that would be aggravated to such an extent that walking 200 feet would be life threatening.*

* If checking one of these definitions, please specify disability _____

This Disability is:

- ☐ Permanent
- ☐ Temporary - if temporary, state duration _____

I certify by my signature as a licensed physician or chiropractor, that _____ in my professional opinion, meets the definition(s) I have checked above, and is entitled to the applied for permit. I would be guilty of a misdemeanor for fraudulently certifying the applicant.

_____ Physician or Chiropractor Signature and Title

_____ Telephone Number

_____ Physician or Chiropractor Printed Name

_____ Address

_____ City/State