TERRITORY OF GUAM
DEPARTMENT OF REVENUE & TAXATION
MOTOR VEHICLE DIVISION

NAME: _____ _____ _____ SOCIAL SECURITY NUMBER: _____
(LAST) (FIRST) (INT)

MAILING ADDRESS: _____ _____
STREET NUMBER/P.O.BOX ZIP CODE

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____ SEX: _____ PHONE NO.: _____
FEET/INCHES POUNDS (M/F)

1. Do you have a current accessible parking placard? _____Yes _____No If yes, Placard Number(s): _____

   Expiration Date: _____

2. Do you have a current accessible parking license plate? _____Yes _____ No If yes, License Plate Number: _____

   Expiration Date: _____

3. Are you applying for accessible parking Placard _____ and/or accessible parking License Plate: _____?

I declare under penalty of perjury that the foregoing is true and correct.

I authorize the release of medical information to process this application.

NOTE: Upon renewal of my accessible parking placard (permanent status), I will personally appear to Department of Revenue and Taxation. Otherwise, I must obtain another Certification from my physician.

APPLICANT'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S CERTIFICATION

Section 1. Purpose. The purposes of this act are to establish a uniform system for accessible parking for persons with disabilities to enhance access and the safety of persons who have disabilities which limit or impair the ability to walk, and to conform with the requirements of the Americans with Disabilities Act. Accessibility Guidelines as they apply to accessible parking.

LOSS OF USE OF LOWER LIMB(S):

Condition:			Special Equipment		
	[] Amputation	[] Birth Defect		[] Artificial Limb(s)	[] Braces
	[] Multiple Sclerosis	[] Muscular		[] Cane(s)	[] Crutch(es)
	[] Paraplegic	[] Dystrophy		[] Walker	[] Wheel Chair
	[] Other_____	[] Polio		[] Other_____	

RESPIRATORY CONDITION:

[ ] Is restricted by lung disease to such an extent that the person's forced (respiratory) expiatory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty (60) mm/hg on room air at rest.

EYE(s) CONDITION:

[ ] Has a central visual acuity that does not exceed 20/200 in the better eye, with corrective lens, as measured by the Snellen test, or visual activity greater than 20/200, but with a limitation in the field of vision such that the widest diameter of the visual field subtends an angle not greater than 20 degrees.

HEART CONDITION CLASSIFICATION: (By the standards set by the American Heart Association)

[ ] Class III [ ] Class IV

OTHER DIAGNOSES DISEASED OR DISORDER, WHICH CREATES A SEVERE WALKING MOBILITY LIMITATION (cannot walk two hundred feet (200') without stopping to rest due to):

[ ] Arthritic [ ] Neurological [ ] Orthopedic [ ] Other_____

I, the undersigned, being duly licensed to practice in Guam, certify under the penalties of perjury that I am personally aware of the degree of impaired mobility of the person identified in this application as indicated above. It is my professional opinion that this applicant should qualify for the issuance of the special Parking Placard having a condition due to the significant physical mobility limitations and/or for the safety of the applicant.

[ ] APPROVED - PERMANENT DISABILITY

[ ] APPROVED (TEMPORARY DISABILITY) NOT TO EXCEED SIX (6) MONTHS

[ ] DISAPPROVED (MOBILITY IS NOT AFFECTED BY CONDITION(S): _____

_____ _____
PHYSICIAN'S SIGNATURE PRINT NAME

_____ _____
CLINIC ADDRESS/TELEPHONE

I, the undersigned, being duly licensed to practice in Guam, certify under the penalties of perjury that I am personally aware of the degree of impaired mobility of the person identified in this application as indicated above. It is my professional opinion that this applicant should qualify for the issuance of the special Parking Placard having a condition due to the significant physical mobility limitations and/or for the safety of the applicant.

[ ] APPROVED - PERMANENT DISABILITY

[ ] APPROVED (TEMPORARY DISABILITY) NOT TO EXCEED SIX (6) MONTHS

[ ] DISAPPROVED (MOBILITY IS NOT AFFECTED BY CONDITION(S): _____

_____ PHYSICIAN'S SIGNATURE

_____ PRINT NAME

_____ CLINIC

_____ ADDRESS/TELEPHONE

** FOR OFFICIAL USE BY DEPARTMENT OF REVENUE AND TAXATION**
VEHICLE REGISTRATION BRANCH
ACCESSIBLE PARKING

[ ] NEW [ ] RENEWAL [ ] REPL. PLACARD NO. _____ EXP. DATE: _____ PREVIOUS PLACARD NO. _____

COMMENTS: _____