DMV USE ONLY	☐ NEW ☐ REPLACEMENT	PERMIT NUMBER(S)	PLATE NUMBER	EXPIRES	MO.	YEAR

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
OVER THE COUNTER SALES UNIT
60 STATE STREET, WETHERSFIELD CT 06161-5052
Telephone: (860) 263-5154
dmv.hpapp@ct.gov
On the web at ct.gov/dmv

RENEWABLE PARKING PLACARD -

APPLICATION FOR A PERSON WHO IS BLIND OR HAS A DISABILITY
B-225P Rev. 10-2023

INSTRUCTIONS:
PART A must be completed by applicant. Applicant must have a Connecticut License or ID card. If you are blind and hold a license, you must surrender it at a full service office of the DMV when this application is submitted. A non-driver photo ID may be obtained in place of the license. For additional questions please call.

PART B must be completed and signed by a physician, APRN, physician assistant or in the case of a veteran with PTSD, by a psychiatrist with the U.S. Department of Veterans Affairs. In the case of blindness, an optometrist, ophthalmologist or the Connecticut Board of Education and Services for the Blind may complete PART B or submit a copy of certificate of blindness. **Stamped signatures are not permissible.**

The applicant must return this form by mail to the address above online or, in person at any DMV branch office by appointment only, or via e-mail. ***There is no charge for a renewable permit.***
Before renewal of your permit, the driver's license or non-driver identification card must be renewed.

PART A - COMPLETED BY APPLICANT

TYPE OF APPLICATION ☐ **NEW** (*1st issue*) ☐ **REPLACEMENT** ☐ **RENEWAL**

APPLICANT IS *(Check One)*
☐ **DISABLED** ☐ **BLIND** ☐ **GUARDIAN OF BLIND OR DISABLED PERSON** ☐ **ORGANIZATION TRANSPORTING BLIND OR DISABLED PERSON** ☐ **QUALIFYING VETERAN (See C below)**

IDENTIFICATION OF APPLICANT *(Please Print)*

NAME OF PERSON WHO IS BLIND OR DISABLED *(Last, First, Middle Initial)*			GUARDIAN OR ORGANIZATION
DATE OF BIRTH *(Required)*	CT DRIVER LICENSE/ID CARD NUMBER *(Required)*		DAYTIME TELEPHONE NUMBER
ADDRESS *(No. and Street)*	*(City or Town)*	*(State)*	*(Zip Code)*
MAILING ADDRESS *(No. and Street)*	*(City or Town)*	*(State)*	*(Zip Code)*

I certify under penalty of false statement that I am blind, or a person who has a disability that limits or impairs the ability to walk, as described in Part B, or a veteran with PTSD and a disability defined in C below, or I am the parent or guardian of such person and certifying such condition on his or her behalf. If a Power of Attorney is submitted, it must be attached to this application.

APPLICANT'S SIGNATURE	SIGNATURE OF APPLICANT/PARENT/GUARDIAN *(or Power of Attorney)*	DATE SIGNED
	X	

PART B - COMPLETED BY PHYSICIAN, APRN, PHYSICIAN ASSISTANT, OPTOMETRIST, OPHTHALMOLOGIST, BESB OR USDVA PSYCHIATRIST

If completed by USDVA psychiatrist, you are also certifying that the person is a veteran as defined in CGS section 27-103(a) and has one or more physical disabilities that limit or impair the ability to walk as defined in #B 1 through 6 of the criteria below.

CRITERIA TO QUALIFY

The applicant may obtain a placard if they meet one or more of the following conditions:

A. The applicant is blind *(Must be certified by an optometrist, ophthalmologist or by Board of Education and Services for the Blind- BESB);* OR

B. The applicant has a disability that limits or impairs their ability to walk. These conditions are defined in 23 CFR 1235.2 and are listed below *(Must be certified by Physician, Physician Assistant or Advance Practice Registered Nurse- APRN):*

1. The applicant cannot walk two hundred feet without stopping to rest; or
2. The applicant cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other device; or
3. The applicant is restricted by lung disease to such an extent that the person's 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 on room air at rest; or
4. The applicant uses portable oxygen; or
5. The applicant has a cardiac condition to the extent that the their functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association; or
6. The applicant is severely limited in the ability to walk due to an arthritic, neurological, or orthopedic condition; OR

C. The applicant is a veteran with PTSD and a disability that limits or impairs the ability to walk, as defined in # B1 through 6 above *(PTSD and veteran status must be certified by a psychiatrist with the U.S. Department of Veterans Affairs-USDVA)*

CERTIFIER'S NAME *(Please print)*	CHECK ONE ☐ PHYSICIAN ASSISTANT ☐ BESB ☐ USVA PSYCHIATRIST ☐ PHYSICIAN ☐ APRN ☐ OPTOMETRIST ☐ OPHTHALMOLOGIST
MEDICAL LICENSE NUMBER *(Required)*	MEDICAL LICENSING STATE *(Required)*

OFFICE ADDRESS *(No. and Street)*	*(City or Town)*	*(State)*	*(Zip Code)*	OFFICE TELEPHONE NUMBER

ADDITIONAL CERTIFICATION MAY BE REQUIRED AT THE TIME OF THE ORIGINAL APPLICATION OR ANY TIME THEREAFTER IF THERE IS CAUSE TO BELIEVE THAT THE ABILITY TO WALK IS NOT SERIOUSLY AND PERMANENTLY IMPAIRED.

PHYSICIAN, PHYSICIAN ASSISTANT, APRN, OPTOMETRIST, OPHTHALMOLOGIST, USDVA PSYCHIATRIST, STATEMENT AND SIGNATURE

I certify under the penalty of false statement in accordance with sections 14-110 and 53a-157b of the Connecticut General Statutes that the person named in this application meets one or more of the qualifying criteria defined above. I understand that if I make a certification that I know or believe is not true with the intent to mislead the Commissioner, I will be subject to prosecution under the above-cited laws. The applicant's condition is **PERMANENT (Up to 8 years).**

SIGNATURE OF PHYSICIAN, PA, APRN, OPTOMETRIST, OPHTHALMOLOGIST, OR USDVA PSYCHIATRIST	DATE SIGNED
X	

Note: Only 1 placard will be issued per disabled individual.