TOWN OF SOUTHAMPTON

Main Office
116 HAMPTON ROAD
SOUTHAMPTON, NY 11968
Phone: (631) 287-5740
Fax: (631) 283-5606

OFFICE OF TOWN CLERK
SUNDY A. SCHERMEYER

Town Clerk Annex
Phone: (631) 723-2712
Fax: (631) 723-3080
Website:
www.southamptontownny.gov

DISABLED PARKING APPLICATION

Please provide a copy of the applicant's **Driver's License** or **Non-Driver Photo-ID** when applying/renewing.

Please have your physician fill out the back of this form, ***OR*** attach to this application, a letter on physician's stationery describing your need for a disabled permit and type of permit required.

PERMANENT DISABILITIES: May be certified by a Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP), Doctor of Podiatric Medicine (DPM, for disabilities related to the foot), or Optometrist (OD, for blindness).
TEMPORARY DISABILITIES: May be certified ***only by*** a Medical Doctor or Doctor of Osteopathy

Village residents of **Southampton & Sag Harbor** must obtain disabled permits from those Village Clerks.

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NAME OF DISABLED PERSON: ____

PHYSICAL ADDRESS: ____

MAILING ADDRESS (*if different*:____

PHONE # __________________________ E-MAIL: ____

BIRTHDATE:___________________________ SEX: Male ☐ Female ☐

DRIVER'S LICENSE / NON-DRIVER'S ID#: ____

License/ID MUST reflect a Southampton Township address.

I ACKNOWLEDGE THAT I UNDERSTAND THE CONDITIONS OF THE DISABLED PARKING PERMIT AND THAT I SHALL OBSERVE AND COMPLY WITH SAME.

APPLICANT / GUARDIAN'S SIGNATURE ____

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For office use only:

______New Permit________Renewal_______Replacement

_____ Permanent OR _____ Temporary

ISSUED ______________________ EXPIRES _____________________ PERMIT #____________________

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For Physician Use Only!

Dear Physician,

The abuse of disabled permits has become a serious problem. The number of permits issued far exceeds the space availability, and we are requesting your assistance in this matter. Your discretion in signing the permit application and gauging the duration of its use is extremely important! We ask that you only issue requests for disabled permits to persons with **mobility–related** impairments. Thank you in advance for your cooperation; your discretion is appreciated!

NAME OF INDIVIDUAL:____

NATURE OF PATIENT'S DISABILITY:______________________________

TYPE OF PERMIT REQUIRED:
☐ Permanent (3 Years)
☐ Temporary________Months (6 Months Maximum)

PHYSICIAN'S NAME:____________________________ID #: ________________
(MD/DO/DPM/NP/PA/OD)

PHYSICIAN'S SIGNATURE:________________________DATE: ________________

Physician's Address & Phone Number

PERMANENT HANDICAP PERMITS ARE VALID FOR 3 YEARS FROM DATE OF ISSUE