



APPLICATION for UNIVERSAL DISABILITY PASS

NAME _____
First Name Full Middle Name Last Name

DNRid # _____ Phone Number _____

Signature _____ Date: _____

Include one of the following:

1. Copy of your Veterans Affairs disability determination letter
2. Copy of your MVA Disability Parking Certification
3. Certification (below) by a licensed health care professional

CERTIFICATION of DISABILITY

I hereby certify that applicant suffers from the impairment(s) detailed below
that substantially limits one or more major life activities.

Condition is ☐ permanent ☐ temporary -- anticipated to last until _____

Printed name *Signature – licensed health care provider*

Specialty: ☐ physician ☐ chiropractor ☐ optometrist ☐ podiatrist ☐ nurse practitioner

Address: _____

Telephone: _____ Email: _____

Medical license # _____ Issuing state _____ Exp date _____

OFFICE USE ONLY

Approval date: _____ By: _____