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

All applicants must present a copy of drivers license or non-driver photo ID when applying/renewing in person or by mail.

Please have your physician (NYS licensed M.D. or D.O.) fill out the back of this form, ***OR*** attach to this application, a letter on physician's stationary describing your need for a disabled permit.

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

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NAME OF DISABLED PERSON: ____

ADDRESS: ____

ZIP CODE: ______________________________ PHONE: ___________________________________

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 #: ____________________

PHYSICIAN'S SIGNATURE: _____________________________DATE: ____________________

Physician's Address & Phone Number

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