



## HANDICAPPED PARKING PRIVILEGE APPLICATION

SFTC FORM 8-6

I hereby make application to the Sac and Fox Tax Commission for handicapped parking privileges. I understand that in order to park in certain parking areas designated for the disabled, I must display either the reflective insignia (bumper stickers) or parking certificate (removable permit). I understand that these items may only be displayed on motor vehicles either owned and operated by me or in which I am a passenger. I further understand that any person who knowingly makes false application for or unauthorized use of a parking certificate or insignia is guilty of a misdemeanor and, upon conviction thereof, shall be punished in accordance with the laws of the Sac and Fox Nation.

**REFLECTIVE INSIGNIA** This is a set of bumper stickers which are placed on the front and rear bumpers of the vehicle the applicant owns and is the primary driver of. **NON-DRIVERS ARE NOT ELIGIBLE FOR THE BUMPER STICKERS.**

**A PHOTOSTATIC COPY OF CAR TITLE MUST BE SUBMITTED IN ORDER TO OBTAIN BUMPER STICKERS.**

**PLEASE HAVE YOUR PHYSICIAN COMPLETE THE FOLLOWING:**

Patient's Name: \_\_\_\_\_

What is patient's disability? \_\_\_\_\_

Does disability cause walking long or short distance to be difficult? \_\_\_\_\_

Please indicate if disability will be permanent: YES NO If no, please estimate length of time your patient will require special parking privileges: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ Signature: \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_ Telephone: \_\_\_\_\_

For office Use Only
Certificate Number _____
Insignia Number _____
Type of Car _____
Date Issued _____
Expiration Date _____

PLEASE PRINT THE FOLLOWING INFORMATION

APPLICANT \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

DRIVER'S LICENSE \_\_\_\_\_

Signature \_\_\_\_\_

MAIL COMPLETED APPLICATION TO:  
 SAC AND FOX NATION TAX COMMISSION  
 MOTOR VEHICLE REGISTRATION DIVISION

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ROUTE 2, BOX 246, STROUD, OKLAHOMA 74079 (918) 968-3526 FAX: (918)968-3887