City of Miami Beach Parking Department
1755 Meridian Avenue Miami Beach FL, 33139
Tel.: (305) 673-7505 www.miamibeachparking.com

DISABLED MUNICIPAL PARKING APPLICATION

Disabled Placard Owner Information:

Name:	
Address:	
City/State/Zip Code:	
Email:	
Phone:	
Driver License Number:	

Vehicle Driver Information: ☐ Same as Above

Name:	
Address:	
City/State/Zip Code:	
Email:	
Phone:	
Driver License Number:	

Vehicle Information:

Tag:		Color:	
State:		Year:	
Make:		Model:	
Tag:		Color:	
State:		Year:	
Make:		Model:	

Issuing Practitioner Information:

Certification/License No. *(Required)* ______________________________ of Physician, Osteopathic or Podiatric Physician, Chiropractor, Optometrist, Advanced Practice Registered Nurse under the protocol of a licensed physician or Physician Assistant licensed under Chapter 458 or 459.				Licensed in State of
Print/Type Name of Certifying Authority	Business Address	City	State	Zip Code
Telephone Number	☐ **SPECIAL EXCEPTION:** The severely disabled applicant named above that was issued a permanent placard is unable to obtain a Florida Driver License or ID Card.			

PLEASE NOTE:

- This application must be submitted with a copy of your Disabled Placard, Disabled Placard Registration and current Vehicle Registration. All must be valid and used in accordance with Florida Statute 320.0848 and City of Miami Beach Statute Code of Ordinances section 106-55(l)(4). This permit allows for parking access to legal Municipal Parking Spaces. Access to Residential Parking Spaces requires a Residential Parking Permit.
- Your license plate (tag) number will serve as your virtual permit. This means that an Enforcement Officer with a License Plate Recognition (LPR) reader will scan your license plate and confirm its validity. Please notify us of any change to your vehicle or license plate ASAP to avoid being cited or towed.
- This parking permit requires the display of the disabled placard. A registered tag and an accompanying disabled placard are required for waiver of parking fees.

By execution of this Disabled Residential Parking Permit Application, I hereby swear and affirm that I fully understand that all permits are the sole property of the City of Miami Beach Parking Dept. I acknowledge that said permit is for the sole use of the owner of the disabled placard or for the use of a person transporting a disabled person and not intended for resale nor transferable. Any violation(s) of the permit regulations may result in the termination of parking privileges.

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DISABLED MUNICIPAL PARKING APPLICATION

CITY OF MIAMI BEACH VOLUNTARY DISABLED PERSON PARKING REGISTRATION PROGRAM MEDICAL CONTACT CONSENT FORM

I, ___________________________________, have submitted an application to be registered in the City of Miami Beach Voluntary Parking Registration Program pursuant to Section 106-55(l)(4) of the Code of Ordinances of the City of Miami Beach (the "Program"). I certify that I am a person with one of the disabilities listed in section 320.0848 of the Florida Statutes. I further state that my physician or other certifying practitioner has completed the statement of certification, as required in section 320.0848, Florida Statutes, in connection with the Application for Disabled Person Parking Permit (Form 83039) submitted by me, or on my behalf, to the Florida Department of Highway Safety and Motor Vehicles to enable me to obtain a Disabled Person Parking Permit. I acknowledge and agree the City must verify the authenticity of my Disabled Person Parking Permit as a condition of my participation in the Program by contacting the physician or other certifying practitioner who completed the statement of certification to verify that such physician or other certifying practitioner exists, is properly licensed and, in fact, certified that I have a qualifying disability. By submitting this form, I grant the City of Miami Beach and its employees my permission to contact my physician or other certifying practitioner listed in Exhibit A for the foregoing purposes. I also release and authorize the physician/medical professional to provide the City with the specified (limited) information.

____
Print Name

____
Signature

____
Date

EXHIBIT A
HEALTHCARE PROVIDER CONTACT INFORMATION

Name of Doctor/Medical Professional: ____

Address: ____

Phone Number: ____

Email (if applicable): ____

STATE OF FLORIDA
COUNTY OF MIAMI DADE

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this _____ day of ______________, 20____, by (Name)______________________, as (Title)_____________________ for(Company)_______________. She/He ☐ is personally known to me or ☐ produced _________________________ as identification.

Notary Public: _________________________________

My Commission Expires: ____________________________