

DMV USE ONLY	<input type="checkbox"/> NEW	PERMIT NUMBER(S)	PLATE NUMBER	EXPIRES	MO.	YEAR
	<input type="checkbox"/> REPLACEMENT					

**SPECIAL PERMIT APPLICATION
AND IMPAIRMENT CERTIFICATE**
B-225 REV. 5-2009



STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
 HANDICAPPED UNIT
 60 STATE STREET, WETHERSFIELD, CT 06161-5056
On The Web At ct.gov/dmv
 Telephone: (860) 263-5154
 Fax: (860) 263-5556
 dmvhpapp@ct.gov

INSTRUCTIONS:

- PART A** must be completed by applicant.
 NOTE: If impairment is blindness and you hold a valid Connecticut Driver License, the license must be surrendered at a full service office of the Department of Motor Vehicles when special permit application is submitted. For purpose of identification, a non-driver photo ID may be obtained in place of the Driver's License.

PART B must be completed and signed by a physician or APRN. An optometrist or ophthalmologist may complete PART B in case of visual impairment.

 If **PART A** and **PART B** are not completed in full, the application will be returned and the special permit will not be issued.
 - The applicant must return this form by mail to the address above, in person at any DMV branch office, or via fax or e-mail. *There is no charge for a permanent permit, however, there is a **\$5.00 charge for temporary permits.*** In the case of a permanent condition, the applicant may obtain Handicapped Plates.
- NOTE: Only one (1) permit will be issued/allowed in connection with a single disabled person.

VALIDATED BY DMV ABOVE

PART A - COMPLETED BY APPLICANT

TYPE OF APPLICATION				
<input type="checkbox"/> NEW (1st issue)		<input type="checkbox"/> REPLACEMENT		
IDENTIFICATION OF APPLICANT (Please Print)	APPLICANT IS (Check One)			
	<input type="checkbox"/> PERSON WHO IS DISABLED <input type="checkbox"/> PERSON WHO IS BLIND <input type="checkbox"/> PARENT/GUARDIAN OF PERSON WHO IS DISABLED OR BLIND <input type="checkbox"/> ORGANIZATION TRANSPORTING BLIND OR DISABLED PERSON			
	NAME OF PERSON WHO IS BLIND OR DISABLED (Last, First, Middle Initial)		DATE OF BIRTH (Required)	DAYTIME TELEPHONE NO.
	NAME OF PARENT OR GUARDIAN OF BLIND OR DISABLED PERSON, IF APPLICANT			
	ADDRESS (No. and Street)	(City or Town)	(State)	(Zip Code)
	MAILING ADDRESS (No. and Street)	(City or Town)	(State)	(Zip Code)
APPLICANT'S SIGNATURE	I, the person who is blind or disabled or the parent or guardian of such person do hereby declare, under penalty of false statement, that the visual acuity or the ability to walk of the above named person is seriously impaired as specified.			
	SIGNATURE OF APPLICANT		DATE SIGNED	
X				

PART B - COMPLETED BY PHYSICIAN, APRN, OPTOMETRIST OR OPHTHALMOLOGIST

PHYSICIAN'S, APRN'S, OPTOMETRIST'S OR OPHTHALMOLOGIST CERTIFICATION OF DISABILITIES AS DEFINED IN 23 CFR PART 1235.2	I hereby certify that the above named applicant is blind or has disabilities that limit or impair their ability to walk, and that his or her condition is:		
	PERMANENT <input type="checkbox"/> TEMPORARY (6 MONTHS OR LESS) <input type="checkbox"/>		
PHYSICIAN'S, APRN'S, OPTOMETRIST'S OR OPHTHALMOLOGIST'S NAME (Please print)		CHECK ONE	
		<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> APRN <input type="checkbox"/> OPTOMETRIST <input type="checkbox"/> OPHTHALMOLOGIST	
LICENSE NUMBER (Required)		LICENSING STATE (Required)	
OFFICE ADDRESS (No. and Street)		(City or Town)	(State) (Zip Code)
		OFFICE TELEPHONE NUMBER	
PHYSICIAN'S, APRN'S, OPTOMETRIST'S OR OPHTHALMOLOGIST'S STATEMENT AND SIGNATURE	SIGNATURE OF PHYSICIAN, APRN, OPTOMETRIST OR OPHTHALMOLOGIST		DATE SIGNED
	X		
The information provided to the Commissioner of Motor Vehicles herein is subscribed by me, the undersigned, under penalty of false statement, in accordance with the provisions of Section 14-110 and 53a-157b of the Connecticut General Statutes. I understand that if I make a statement which I do not believe to be true with the intent to mislead the Commissioner, I will be subject to prosecution under the above-cited laws.			