



INCORPORATED VILLAGE OF OCEAN BEACH

P.O. BOX 457, OCEAN BEACH, NEW YORK 11770-0457
TEL: (631) 583-5940 FAX: (631) 583-7597

2010
MEDICAL/DISABILITY PERMIT APPLICATION

*****ANNUAL FEE: \$20.00*****
NON-REFUNDABLE

INCOMPLETE APPLICATIONS WILL BE RETURNED

New Applicant _____ Renewal _____ Lost Plate Fee: \$ 10.00

APPLICANT'S NAME: _____

MAILING ADDRESS: _____

FIRE ISLAND ADDRESS: _____

FIRE ISLAND COMMUNITY: _____

TELEPHONE NUMBER: _____

CHECK ONE OF THE FOLLOWING:

_____ Bicycle

_____ Tricycle

_____ Single Seat Motorized Cart (Certificate of Insurance Must Be Provided)

_____ Electric _____ Gas _____ Make _____ Model _____ Color

_____ Multi-Seat Motorized Cart (Certificate of Insurance Must Be Provided)

_____ Electric _____ Gas

* Current Driver's License Must Be Included for Multi-Seat Motorized Carts

PHYSICIAN'S STATEMENT ON REVERSE MUST BE COMPLETED

SPECIAL NOTE: CODE 156-9 RE MOTORIZED CART WILL BE STRICTLY ENFORCED.

"No passengers or freight or other items of a non-personal nature shall be carried on such a vehicle".

FOR OFFICE USE ONLY

Date Application Received: _____ Fee Paid: \$20.00 Cash Receipt No.: _____

Approved: _____ Conditions (if any): _____

Comments: _____

Denied: _____ Comments: _____

Authorization: _____
(Mayor's Signature)

Effective Date: _____ Permit No.: _____



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MEDICAL/DISABILITY PERMIT APPLICATION

PHYSICIAN'S STATEMENT FOR APPLICANT'S NEED OF MEDICAL PERMIT

Dear Physician:

The Incorporated Village of Ocean Beach is an island community without cars, two long city blocks wide and ten short city blocks long. Bicycle riding is prohibited in the summer season when the sidewalks are congested with pedestrians for the safety of bicycle riders and pedestrians alike.

In-season permits are granted for those persons with medical problems for whom bicycle, adult tricycles or single seat motorized carts are safe and who require these assisted modes of transportation because of their problems in order that they may obtain household necessities.

1. NAME OF APPLICANT: _____
2. APPLICANT'S DATE OF BIRTH: _____
3. MEDICAL DIAGNOSIS: _____

4. EXPLAIN IN LAY LANGUAGE WHY THIS DIAGNOSIS IMPAIRS THE APPLICANT'S ABILITY TO WALK AND WHY YOU ADVISE THE USE OF A BICYCLE, TRICYCLE, OR SINGLE SEAT MOTORIZED CART: _____

5. DURATION OF DISABILITY _____
6. PHYSICIAN ADVISES USE OF: _____ () BICYCLE
() TRICYCLE
() SINGLE SEAT MOTORIZED CART
() MULTI SEAT MOTORIZED CART
7. DOES APPLICANT NEED ASSISTANCE FROM ANOTHER INDIVIDUAL TO OPERATE ITEM SELECTED IN QUESTION #6 ABOVE? YES/NO (circle one)

DATE

PHYSICIAN'S SIGNATURE

PHYSICIAN'S PRINTED NAME

PHYSICIAN'S ADDRESS

PHYSICIAN'S TELEPHONE NUMBER