New Jersey Department of Community Affairs
Division of Fire Safety
Contractor Certification and Emblems Unit
PO Box 809
Trenton, New Jersey 08625-0809

Phone: 609.324.3560
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DISABILITY AND OXYGEN EMBLEM APPLICATION

A. Application: ☐ New ☐ Update

B. Name of Applicant (Last, First, Middle Initial)

_____

Applicant's Mailing Address: _____

_____

_____

Applicant's Telephone: _____

Applicant's Birth Date: _____

C. Name of Co-Applicant (Last, First, Middle Initial)

_____

Co-Applicant's Mailing Address: _____

_____

_____

Co-Applicant's Telephone: _____

Co-Applicant's Birth Date: _____

FOR OFFICIAL USE ONLY

☐ Accepted ☐ Rejected Muni Code:

APPLICANT PHYSICIAN INFORMATION

1. Name of Physician (Last, First, Middle Initial)

_____

2. Physician's Mailing Address: _____

_____

_____

3. Physician's Telephone: _____

4. Physician's Signature & Date:

_____

TYPE OF EMBLEM REQUESTED

☐ 5" Inside Glass Mount ☐ 7" Inside Glass Mount
☐ 5" Outside Mount ☐ 7" Outside Mount

APPLICANT MEDICAL INFORMATION

Does Applicant Have a Current Handicapped Parking Placard?

☐ Yes Expiration Date: _____
☐ No Please check below which best describes disability.

☐ Severely or permanently disabled
☐ Must use device for assistance (please check which device)
- ☐ Cane
- ☐ Crutch
- ☐ Wheelchair
- ☐ Prosthetic Device
- ☐ Other person
- ☐ Other (Explain) _____

_____

_____

- ☐ Lung Disease
- ☐ Cardiac Condition with class III limitation *
- ☐ Cardiac Condition with class IV limitations*
- ☐ Deaf
- ☐ Hard of Hearing
- ☐ Permanent Sight impairment **

** As defined by the American Heart Association*

*** As defined by the New Jersey Commission for the blind*

☐ Ability to walk is severely limited to:
- ☐ Arthritic Condition
- ☐ Neurological Condition
- ☐ Orthopedic Condition

☐ Oxygen (Tank or Oxygen Delivery System)

APPLICATION MUST BE REVIEWED EVERY TWO YEARS

Applicant's Signature & Date:

_____

Co-Applicant's Signature & Date:

_____