

**AFFIDAVIT FOR "NO FEE" VEHICLE STICKER**

Applicant's Name \_\_\_\_\_  
(Last) (First) (Middle initial)  
Address \_\_\_\_\_ Zip code \_\_\_\_\_  
(Unit #)  
Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

**\*Note: If application is being completed on behalf of a disabled individual, please include the following information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_ Signature \_\_\_\_\_

**Persons with Disabilities definition: Every natural person who has permanently lost the use of a leg or both legs or arm or both arms or any combination thereof or any person who is so severely disabled as to be unable to walk without the aid of crutches, tripod type cane, walker or wheelchair.**

**I hereby apply for a "no fee" sticker under the above provision and certify that my physical condition entitles me to the use of this sticker. I understand that the unauthorized use of the wheelchair sticker under the above provision and certify that my that my physical condition entitles me to the use of this sticker. I understand that the unauthorized use of the wheelchair sticker will lead to its surrender. The Office of the City Clerk may cancel this sticker privilege at any time and holder shall surrender it on demand.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Illinois Disability License Plate Number: W \_\_\_\_\_  
(*Must be disability plate*)

**\*\* You must attach a copy of your current vehicle registration and valid drivers license or state ID**

**PHYSICIAN'S STATEMENT**

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_ Zip code \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_  
(area code)

Physician's Fax Number \_\_\_\_\_  
(area code)

I here by certify that the physical condition of applicant:  
\_\_\_\_\_ requires the **permanent** use of:

(Circle One)

1. Wheelchair 2. Crutches 3. Tripod Cane 4. Walker

Please provide a brief description of the applicant's disability.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_

Physician's Registration Number \_\_\_\_\_

Date: \_\_\_\_\_