

# HANDICAPPED



# APPLICATION

Applicants Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Prescribing Doctor: \_\_\_\_\_ State Doctor Located In: \_\_\_\_\_

PLEASE PRINT LEGIBLY

**With this application, applicant must include a copy of the state placecard/certificate identifying handicapped status.**

Applicant Signature (Required Field): \_\_\_\_\_

With my signature (applicant above) I do understand all the rules associated with this special consideration and will abide by the rules set forth for this status. Furthermore this is for a true disability and not for a convenience of not having to walk in the trials I participate in. Doctors' prescribed exemption will be required with each application. No Exceptions – Note: Copy of Doctor's statement must be attached.

Applicant is responsible for understanding all the rules that are associated with this exemption.

Upon approval, you will be notified by **NBHA s' President**, if your request has been granted. A wallet certificate card will be issued for proof. It is the applicants' responsibility to resubmit this annually for the following years' consideration along with another current Doctor's exemption.

In no way can the **NBHA or its' Officers** can be held liable for the acceptance or rejection of application. Furthermore information that will be made available to the public will only be that this application was granted or applicant has not been granted a handicapped status permit.

Reason for handicapped status request: \_\_\_\_\_

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

Questions or comments: \_\_\_\_\_

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

Accepted  Declined

NBHA Authorized Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_