



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 h

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 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 e 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. I 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 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: _____