

Group Access Pass Application

Applicants must complete both parts of this application,
enclosing all required materials, and mail to:

Access Pass
State Parks
Albany, NY 12238

Please allow 8-10 weeks for processing of this application.



State of New York
David A. Paterson, Governor
www.state.ny.us



Office of Parks, Recreation and Historic Preservation
Carol Ash, Commissioner
www.nysparks.com



Department of
Environmental Conservation
Alexander P. Grannis, Commissioner
www.dec.ny.us

The Office of Parks, Recreation and Historic Preservation is authorized to collect this information by Section 3.09 of the Parks, Recreation and Historic Preservation Law. It will be used to determine your eligibility and to process your application. If the information you provide is not complete, it will not be possible to process your application. The information will be maintained by the Regional Programs and Services Bureau, State Parks, Albany NY 12238, 518-474-2324, TDD 518-486-1899. The information may also be used to contact you about this or other programs of the New York State Office of Parks, Recreation and Historic Preservation.

Part One: Group Information

Group Name

Street Address

City or Town

ZIP Code

Mailing Address if Different Than Street Address

Phone Number

Authorized Representative

Area Code

Last Name

First Name

I authorize the release of any pertinent medical information needed to process this application.

I certify that the above information is true to the best of my knowledge and believe and understand that any person who knowingly files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act.

ANY FALSE STATEMENT MADE HEREIN IS PUNISHABLE AS A CLASS "A" MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.

While passes are not assigned to specific vehicles, each vehicle (including staff vehicles) that is part of a group must present a pass upon entering the facility.

NUMBER OF VEHICLES REQUIRING PASSES:

Signature of Authorized Representative _____ Date _____

Certification cannot be returned

Part Two: Certification

Authorized Representative must complete Section A **OR** Physician must complete Section B.

A. Attach current certification of one of the following:

- Current computer printouts (TPQY) of Social Security records indicating that all group members receive disability insurance benefits under the provisions of the Social Security Act or that disability benefits have been converted to retirement benefits.
- Current certification from the NYS Commission for the Blind and Visually Handicapped that all group members are totally without sight or have central visual acuity of 20/200 or less in the better eye with corrective lenses.
- Current Operating Certificate from the NYS Office of Mental Retardation and Developmental Disabilities or the NYS Office of Mental Health that all group members are recipients of their comprehensive services.
- Current certification from the US Veterans Administration or the NYS Division of Veterans' Affairs that all group members are veterans of a war of the United States and have a 40% or greater service-related disability or that they are eligible for an allowance by the Federal Government for the purchase of an automobile.

The following are NOT acceptable proof of disability:

- Any Social Security Documents which does not clearly state that group members are receiving DISABILITY benefits.
- Social Security check
- NYS Handicapped Parking Permit
- Medicare Card
- Medicaid Card
- VA Treatment Card
- NYS Employees Retirement System — Disability Certification
- NYS Workers Compensation — Disability Certification

B. To be completed by the physician ONLY if one of the certificates of disability listed under Section A is NOT provided.

PHYSICIAN must INITIAL next to applicable statement(s) and complete certification below. A disabling condition (e.g. stroke, heart condition, paralysis, paresis, cancer, emphysema, COPD, ASHD, etc.) is acceptable ONLY if it causes the functional limitation(s) listed below.

I hereby certify that each member of the applicant group is PERMANENTLY DISABLED as indicated by my initials next to the applicable qualification.

_____ Has suffered the loss (not loss of use) of any part of an arm or leg, excluding the extremities of hands and feet;

_____ is totally without sight or has central visual acuity of 20/200 or less in the better eye with corrective lenses;

_____ has hearing loss in excess of 80db (ISO) in the better ear;

_____ is confined to a wheelchair or requires special transportation;

_____ requires physical assistance from another person at all times to ambulate;

_____ needs the assistance at all times of leg brace, crutches, walker or other prosthetic devices to achieve full or partial mobility.

Ambulatory Aid Required: _____

(must be completed by physician)

I certify that the above information is true to the best of my knowledge and believe and understand that any person who knowingly files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act.

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PHYSICIAN INFORMATION:

Last Name

First Name

MI

Street Address

Phone Number

City or Town

State

ZIP Code

License Number

Physician's Signature _____ Date _____

Physician may be requested to recertify this application.