

Disabled Parking Plates or Placard Application

MED 10 (07/01/04)

For Passenger Cars/Pickup or Panel Trucks/Motorcycles

Purpose: To apply for disabled parking plates or placards.

Instructions: Print in ink or type.

A Applicant Information All applicants complete this section.					
Check box(es) that apply	<input type="checkbox"/> Disabled Parking Plates (metal license plates)	Disabled Parking Placard (hangs from rearview mirror) Placard Fee \$5.00 Make check or money order payable to DMV.	<input type="checkbox"/> Temporary	<input type="checkbox"/> Permanent-Original	<input type="checkbox"/> Permanent-Renewal (No physician's/nurse practitioner's certification required)
Full Legal Name	Last	First	Middle	Driver's License or Social Security Number	
If you change either your residence/home address or mailing address to a non-Virginia address, your driver's license or photo identification (ID) card may be canceled.					
Residence/Home Address <input type="checkbox"/> Check here if this is a new address.					
City		State	Zip Code	City or County of Residence	
Mailing Address					
City		State	Zip Code	Daytime Telephone Number ()	
Date of Birth	Gender	Hair Color	Eye Color	Height	Weight
Knowingly making a false claim or statement on this application is punishable as a class 2 misdemeanor. Misuse, counterfeiting, or alteration of disabled placards may result in fines up to \$1000 and up to six months in jail and/or revocation of disabled parking privileges.					
Permanent Disability: I hereby knowingly certify under penalty of fraud and/or perjury that I have a permanent disability that limits or impairs my ability to walk or creates a safety concern while walking, and that all the information I have provided is true.					
Signature:				Date:	
Temporary Disability: I hereby knowingly certify under penalty of fraud and/or perjury that I have a temporary disability that limits or impairs my ability to walk, and that all the information I have provided is true.					
Signature:				Date:	
B Vehicle Information Plate Applicants — Complete this section.					
Vehicle Identification Number (VIN) (Vehicles with model year 1980 and newer must have 17 digits)			Title Number	<input type="checkbox"/> Check here if this vehicle is specially equipped and used for transporting groups of physically disabled persons.	
Check the box(es) that apply <input type="checkbox"/> There are two or more vehicle owners. <input type="checkbox"/> I am the vehicle owner and the parent/legal guardian of a disabled dependent.					
If either box is checked, print the name of each disabled person(s) _____					
C Medical Certification Physician/Nurse Practitioner — Complete this section (not required for renewal).					
I certify and affirm that the above described applicant is my patient whose ability to walk, in my professional opinion, is:					
<input type="checkbox"/> Permanently limited or impaired. A "permanent disability" as it relates to disabled parking privileges shall mean: a condition that limits or impairs movement from one place to another or the ability to walk as defined in Va. Code § 46.2-1240, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.					
<input type="checkbox"/> Temporarily limited or impaired beginning in the month of _____ and ending in the month of _____ (not to exceed 6 months).					
The reason this patient's ability to walk is limited or impaired is checked below:					
Temporary or Permanent Disabilities			Permanent Disabilities Only		
<input type="checkbox"/> Cannot walk 200 feet without stopping to rest.			<input type="checkbox"/> Has been diagnosed with a mental or developmental amentia or delay that impairs judgment including, but not limited to, an autism spectrum disorder.		
<input type="checkbox"/> Cannot walk without the use of or assistance from any of the following: another person, brace, cane, crutch, prosthetic device, wheelchair, or other assistive device.			<input type="checkbox"/> Has been diagnosed with Alzheimer's disease or another form of dementia.		
<input type="checkbox"/> Has a cardiac condition to the extent that functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.			<input type="checkbox"/> Is legally blind or deaf.		
<input type="checkbox"/> Is restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty millimeters of mercury on room air at rest.			<input type="checkbox"/> Other condition that creates a safety concern while walking because of impaired judgment or other physical, developmental, or mental limitation.		
<input type="checkbox"/> Other debilitating condition that limits or impairs the ability to walk. Physician/Nurse Practitioner <u>must</u> specify condition.			Physician/Nurse Practitioner <u>must</u> specify condition.		
The physician's/nurse practitioner's medical license information is required to process this application.					
Physician's/Nurse Practitioner's Name (Print or type.)				Date	
Medical License Number	Medical License Expiration Date	State Issuing Medical License	Office Telephone Number ()		
Physician's/Nurse Practitioner's Signature			Office Fax Number ()		
DMV Use Only					
Date Plate/Placard Issued	Plate/Placard Number	Placard Expiration Date	Employee Stamp		
Credit Card Number	Expiration Date	Fee Collected			