www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

DISABLED PARKING PLACARDS OR LICENSE PLATES APPLICATION

Purpose: Use this form to apply for a disabled parking placard or disabled parking license plates.

Instructions: Submit to any Customer Service Center, DMV Select or mail to DMV, Data Integrity, P.O. Box 85815, Richmond, VA 23285-5815.

- For a parking placard, submit this form with a $5.00 check or money order payable to DMV. Placard will be mailed to you in approximately 15 days. Only one placard may be issued to a customer.
- For disabled parking license plates, submit this form, a License Plate Application (VSA 10) and applicable fees.

DISABLED PARKING PLACARD ONLY
(Disabled parking placard hangs from the rearview mirror.)

CHECK ONE

PERMANENT (5 years)
- ☐ Original (medical professional certification required)
- ☐ Renewal (No medical professional certification required.)

PERMANENT REPLACEMENT (5 years)
- ☐ Lost
- ☐ Stolen
- ☐ Destroyed
- ☐ Mutilated
- ☐ Reissue

TEMPORARY (up to 6 months)
- ☐ Original

TEMPORARY REPLACEMENT
- ☐ Lost
- ☐ Stolen
- ☐ Destroyed
- ☐ Mutilated
- ☐ Reissue

DISABLED PARKING (HP) LICENSE PLATES ONLY

ORIGINAL PLATES
- ☐ Complete and submit form VSA 10

DUPLICATE
- ☐ Lost
- ☐ Destroyed

REISSUE
- ☐ Unreadable (License plate letters or numbers unclear)
- ☐ Never received license plates

☐ Check this box if this vehicle is specifically equipped and used for transporting groups of physically disabled persons.

VEHICLE IDENTIFICATION NUMBER (VIN)	TITLE NUMBER

☐ I am the vehicle owner and the parent/legal guardian of a disabled dependent(s). List the name of each disabled person below.

APPLICANT INFORMATION

FULL LEGAL NAME (last) (first) (middle) (suffix)	DMV ASSIGNED NUMBER OR SOCIAL SECURITY NUMBER

CURRENT RESIDENCE ADDRESS ☐ Check here if this is a new address.	CITY	STATE	ZIP CODE

CITY OR COUNTY OF RESIDENCE	DAYTIME TELEPHONE NUMBER OR CELL PHONE NUMBER
	( )

MAILING ADDRESS (if different from above)	CITY	STATE	ZIP CODE

BIRTH DATE (mm/dd/yyyy)	GENDER	HAIR COLOR	EYE COLOR	HEIGHT	WEIGHT
	☐ MALE ☐ FEMALE			FT IN	LBS

APPLICANT CERTIFICATION

I understand that misuse, counterfeiting, or alteration of disabled placards may result in fines up to $1000. and up to 6 months in jail and/or revocation of disabled parking privileges. I certify that I have a (check one): ☐ Temporary ☐ Permanent disability that limits or impairs my ability to walk or creates a safety concern while walking.

I also understand that the disabled parking placard or plates issued to me cannot be loaned to anyone, including family members or friends, to benefit a person other than myself.

I further certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

APPLICANT SIGNATURE	DATE (mm/dd/yyyy)

LICENSED PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER MEDICAL CERTIFICATION

(This section does not have to be completed to renew permanent placards.)

☐ 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 Virginia Code §46.2-1240, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.

☐ Temporarily limited or impaired beginning in the month of _____ and ending in the month of _____ (not to exceed 6 months).

Reason this patient's ability to walk is limited or impaired or creates a safety condition while walking. (check below)

☐ Cannot walk 200 feet without stopping to rest.

☐ Uses portable oxygen.

☐ 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.

☐ 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.

☐ 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 60 millimeters of mercury on room air at rest.

☐ Is severely limited in ability to walk due to an arthritic, neurological, or orthopedic condition.

☐ Has been diagnosed with a mental or developmental amentia or delay that impairs judgment including, but not limited to, an autism spectrum disorder.

☐ Has been diagnosed with Alzheimer's disease or another form of dementia.

☐ Is legally blind or deaf.

☐ Other condition that limits or impairs the ability to walk. Specific condition description must be specified below.

I certify and affirm that the described applicant is my patient, whose ability to walk, based on my examination, is limited or impaired or creates a safety concern while walking as described above.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

MEDICAL PROFESSIONAL NAME	OFFICE TELEPHONE NUMBER ( )	OFFICE FAX NUMBER ( )

LICENSE TYPE	LICENSE NUMBER (required)	STATE ISSUING LICENSE (required)	LICENSE EXPIRATION DATE (mm/dd/yyyy) (required)

MEDICAL PROFESSIONAL SIGNATURE	DATE (mm/dd/yyyy)

LICENSED CHIROPRACTOR OR PODIATRIST MEDICAL CERTIFICATION

(This section does not have to be completed to renew permanent placards.)

☐ 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 Virginia Code §46.2-1240, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.

☐ Temporarily limited or impaired beginning in the month of _____ and ending in the month of _____ (not to exceed 6 months).

Reason this patient's ability to walk is limited or impaired or creates a safety condition while walking. (Checked below)

☐ Cannot walk 200 feet without stopping to rest.

☐ 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.

☐ Is severely limited in ability to walk due to an arthritic, neurological or orthopedic condition.

☐ Other condition that limits or impairs the ability to walk. Specific condition description must be specified below.

I certify and affirm that the described applicant is my patient, whose ability to walk, based on my examination, is limited or impaired or creates a safety concern while walking as described above.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

MEDICAL PROFESSIONAL NAME	OFFICE TELEPHONE NUMBER ( )	OFFICE FAX NUMBER ( )

LICENSE TYPE	LICENSE NUMBER (required)	STATE ISSUING LICENSE (required)	LICENSE EXPIRATION DATE (mm/dd/yyyy) (required)

MEDICAL PROFESSIONAL SIGNATURE	DATE (mm/dd/yyyy)

DMV USE ONLY

PLATE/PLACARD NUMBER	PLACARD EXPIRATION DATE (mm/dd/yyyy)	EMPLOYEE STAMP

CUSTOMER CREDIT CARD NUMBER	CREDIT CARD EXPIRATION DATE (mm/yy)	FEE COLLECTED