

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) <input type="checkbox"/> Original (medical professional certification required) <input type="checkbox"/> Renewal (No medical professional certification required.)	PERMANENT REPLACEMENT (5 years) <input type="checkbox"/> Lost <input type="checkbox"/> Destroyed <input type="checkbox"/> Reissue	TEMPORARY (up to 6 months) <input type="checkbox"/> Stolen <input type="checkbox"/> Mutilated	TEMPORARY REPLACEMENT <input type="checkbox"/> Original <input type="checkbox"/> Lost <input type="checkbox"/> Stolen <input type="checkbox"/> Destroyed <input type="checkbox"/> Mutilated <input type="checkbox"/> Reissue

DISABLED PARKING (HP) LICENSE PLATES ONLY			
ORIGINAL PLATES <input type="checkbox"/> Complete and submit form VSA 10	DUPLICATE <input type="checkbox"/> Lost <input type="checkbox"/> Destroyed	REISSUE <input type="checkbox"/> Unreadable (License plate letters or numbers unclear) <input type="checkbox"/> Never received license plates	<input type="checkbox"/> Check this box if this vehicle is specifically equipped and used for transporting groups of physically disabled persons.
VEHICLE IDENTIFICATION NUMBER (VIN)		TITLE NUMBER	
<input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		HAIR COLOR		EYE COLOR	HEIGHT FT IN	WEIGHT 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): <input type="checkbox"/> Temporary <input type="checkbox"/> 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)

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Cannot walk 200 feet without stopping to rest. <input type="checkbox"/> Uses portable oxygen. <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 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 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. <input type="checkbox"/> Is severely limited in ability to walk due to an arthritic, neurological, or orthopedic condition. | <ul style="list-style-type: none"> <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"/> Has been diagnosed with Alzheimer's disease or another form of dementia. <input type="checkbox"/> Is legally blind or deaf. <input type="checkbox"/> 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)

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Cannot walk 200 feet without stopping to rest. <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"/> Is severely limited in ability to walk due to an arthritic, neurological or orthopedic condition. | <ul style="list-style-type: none"> <input type="checkbox"/> 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.

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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	