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

MED 10 (08/25/2015)

DISABLED PARKING PLACARD OR LICENSE PLATES APPLICATION

Purpose: Persons with disabilities use this form to apply for a disabled parking placard or disabled parking license plates.

Instructions: **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. Placards purchased in advance of a medical procedure (e.g. surgery) will be mailed 15 days prior to the date of the procedure. Only one placard may be issued to a customer.
For disabled parking license plates, submit this form, a completed License Plate Application (VSA 10) and applicable fees. Submit forms and fees to any Customer Service Center, DMV Select or mail to DMV, Data Integrity, P.O. Box 85815, Richmond, VA 23285-5815.

APPLICANT INFORMATION (person with disability)

FULL LEGAL NAME (last) (first) (middle) (suffix)				DMV ASSIGNED NUMBER OR SOCIAL SECURITY NUMBER		
CURRENT RESIDENCE 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 ☐ MALE ☐ FEMALE	HAIR COLOR	EYE COLOR	HEIGHT FT IN	WEIGHT LBS	

DISABLED PARKING PLACARD (see back of form)

DISABLED PARKING LICENSE PLATES (HP) (must also complete and submit form VSA 10)

☐ The vehicle on which HP plates will be used is specifically equipped and used for transporting groups of physically disabled persons.

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

APPLICANT CERTIFICATION (person with disability)

I understand that misuse, counterfeiting, or alteration of disabled placards may result in fines up to $1000.00 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)

DMV USE ONLY

TEMPORARY PLACARD (up to 6 months)
☐ ORIGINAL ☐ REISSUE ☐ REPLACEMENT (check reason below)
☐ Lost ☐ Stolen ☐ Destroyed/Mutilated

PERMANENT PLACARD (5 years)
☐ ORIGINAL (Medical professional certification required.)
☐ RENEWAL (No medical professional certification required.)
☐ REISSUE
☐ REPLACEMENT (check reason below)
☐ Lost ☐ Stolen ☐ Destroyed/Mutilated

HP PLATES ☐ ORIGINAL PLATES submit completed form VSA 10
DUPLICATE PLATES: ☐ Lost ☐ Destroyed
REISSUE PLATES: ☐ Unreadable (letters/numbers unclear) ☐ Plates never received

15-DAY PLACARD RECEIPT NUMBER

PLACARD EXPIRATION DATE (mm/dd/yyyy)

EMPLOYEE STAMP

The front of this form must be completed before the medical professional signs the certification.

APPLICANT FULL LEGAL NAME (last, first, middle, suffix)

NOTE: (This page does not have to be completed to renew permanent placards.)

DISABILITY TYPE

☐ **Temporarily limited or impaired** beginning date (mm/dd/yyyy) _____ and ending date (mm/dd/yyyy)_____(not to exceed 6 months).

☐ **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.

LICENSED PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER MEDICAL CERTIFICATION

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

☐ 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.

☐ 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).

LICENSED CHIROPRACTOR OR PODIATRIST MEDICAL CERTIFICATION

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.

☐ 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).

LICENSED MEDICAL PROFESSIONAL CERTIFICATION

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.

☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner ☐ Chiropractor ☐ Podiatrist

MEDICAL PROFESSIONAL NAME (print)			OFFICE TELEPHONE NUMBER ( )	OFFICE FAX NUMBER ( )
LICENSE TYPE	LICENSE NUMBER	STATE ISSUING LICENSE (required)	LICENSE EXPIRATION DATE (required)	
MEDICAL PROFESSIONAL SIGNATURE				DATE (mm/dd/yyyy)