



DISABILITY PARKING PLACARD AND/OR TAGS APPLICATION

I am applying for or renewing:

<input type="checkbox"/> Disability Tags	<input type="checkbox"/> Disability Parking Placard	<input type="checkbox"/> Disability Tags and Disability Parking Placard
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You may mail this form to DC Department of Motor Vehicles, PO Box 90120 Washington, DC 20090, or fax to 202-729-7158 or 202-673-9908.

APPLICANT INFORMATION				
Last Name	First Name	Middle Name	Suffix	
Address		Apt/Unit Number	City/State	Zip Code
			WASHINGTON, DC	
Date of Birth	Social Security Number	Telephone Number	Current Placard/Tag Number (For Renewals Only)	
E-Mail Address				

The applicant swears or affirms the following:

I will use the disability placard or tags granted by the DC Department of Motor Vehicles as provided in Chapter 27 of Title 18, District of Columbia Municipal Regulations. I understand the disability parking placard or tags are not transferable to any other person and are intended for my use only. I may have a designated driver display the disability parking placard only when I am a passenger in the vehicle in which the placard is displayed.

The above information is true and correct to the best of my knowledge and belief.

Applicant's Signature:	Date
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IN-PERSON SELF CERTIFICATION		
<p>If you have one of the following disabilities, you can self-certify, if you apply in-person.</p> <p>Please check if applicable:</p> <p>A. <input type="checkbox"/> Missing lower extremity or</p> <p>B. <input type="checkbox"/> Are unable to walk without the aid of a motorized wheelchair</p> <p>You are not required to complete the medical information or physician's certification on Page 2, if you apply in-person at any DC DMV service center. If you mail or fax this form, the medical information and a physician's certification on Page 2 is required.</p>		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%; padding: 5px;">Applicant's Signature:</td> <td style="width: 20%; padding: 5px;">Date</td> </tr> </table>	Applicant's Signature:	Date
Applicant's Signature:	Date	

The making of a false statement on this form is a violation of DC law and subject to a fine of up to \$1,000 or 180 days imprisonment or both. (D.C. Official Code § 22-2405)

(over)

Applicant Name	Social Security Number

MEDICAL INFORMATION
THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN

QUESTIONS A - D APPLY TO LONG-TERM DISABILITIES:

A. Has applicant lost the use of one (1) or both legs?

Yes **No**

B. Is applicant severely disabled and unable to walk without the aid of a mechanical device?
Note: Mechanical device includes wheelchair, walker, crutches, cane and long leg braces.

Yes **No**

C. Does applicant suffer from respiratory disease or ailment?

Note: After consideration of the extent that the Aerial PO2 is less than 60 mmHg, the Forced Vital Capacity ("FVC") is less than 50% of the predicted value, the Forced Expiratory Volume in one second ("FEV1") is less than 40% of the predicted value and the FEV1/FVC is less than 40% of the actual value when measured in liters by a Spiro-meter based on predicted normal values for the individual's sex, age and height.

Yes **No**

D. Does the applicant have a physical disability that is long-term and substantially impairs the individual's mobility?

Yes **No**

QUESTION E APPLIES TO TEMPORARY DISABILITIES:

E. Does the applicant have a physical disability that is temporary and substantially impairs the individual's mobility?

Yes **No**

If yes, physician must estimate duration of disability: From: _____ To: _____

PHYSICIAN CERTIFICATION	
Physician's Identification Number	State
Physician's Name (Print Please)	
Address	
Telephone Number	E-Mail Address
Physician's Signature	Date

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Visit our website www.dmv.dc.gov or call 311 in DC or 202-737-4404 for additional information.
To report waste, fraud, or abuse by any DC Government Agency or official, call the Office of the DC Inspector General at 1-800-521-1639.