



# APPLICATION FOR DISABILITY PARKING PLACARD OR TAGS

I am applying for or renewing: (only check ONE)

**Disability Tags** (DC Residents Only) **OR**  **Disability Parking Placard**

You may mail this form to DC DMV, Medical Review Services, PO Box 90120 Washington, DC 20090, or fax to 202-727-0463.  
For additional information visit our website: [www.dmv.dc.gov](http://www.dmv.dc.gov) or call our Customer Service Call Center at 202-727-5000.

## APPLICANT'S INFORMATION

**NAME:** \_\_\_\_\_  
FIRST MIDDLE LAST

**ADDRESS:** \_\_\_\_\_  
STREET CITY STATE ZIP CODE

**SOCIAL SECURITY NO:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**TELEPHONE NO.** \_\_\_\_\_ **Current Placard/Tag No:** \_\_\_\_\_ (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

## IN-PERSON SELF CERTIFICATION

If you have a missing lower extremity or are unable to walk without the aid of a motorized wheelchair, the medical information and physician's certification on Page 2 is NOT required if you apply in-person at any DC DMV service center. If you mail or fax this form, the medical information and physician's certification on Page 2 is required.

\_\_\_\_\_  
Applicant's Signature Date

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

*To report waste, fraud and abuse by any DC Government Official or agency, call the DC Inspector General at 1-800-521-1639.*

Applicant's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

## MEDICAL AND PHYSICIAN INFORMATION

**THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN**

Questions A-D apply to Long-Term Disabilities:

A. Has applicant loss 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 PO<sub>2</sub> 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 ("FEV<sub>1</sub>") is less than 40% of the predicted value and the FEV<sub>1</sub>/FVC is less than 40% of the actual value when measured in liters by a spirometer 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 Disability:

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'S CERTIFICATION

Physician's Identification Number and State: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

PLEASE PRINT

Address: \_\_\_\_\_

STREET

CITY

STATE

ZIP CODE

Telephone: ( ) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_