GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLES

DISABILITY PARKING PLACARD AND/OR TAGS APPLICATION

I am applying for or renewing:

❒ Disability Tags	❒ Disability Parking Placard	❒ Disability Tags and Disability Parking Placard

If applying for a Disability parking placard: You may mail this form to DC Department of Motor Vehicles, PO Box 90120 Washington, DC 20090, or fax to 202-673-9908.

If applying for Disability Tags: You may mail this form and a $10 check or money order (replacement tag fee) made payable to: ***DC Treasurer*** to the above mentioned address. Faxes will not be accepted.

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

IN-PERSON SELF CERTIFICATION

If you have one of the following disabilities, you can self-certify, if you apply in-person.

Please check if applicable:

A. ❒ Missing lower extremity or

B. ❒ Are unable to walk without the aid of a motorized wheelchair

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.

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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