STATE OF CALIFORNIA
DMV
Department of Motor Vehicles

APPLICATION FOR DISABLED PERSON PLACARD OR PLATES

Please read all the information on Page 1 before completing this form.

IMPORTANT! Applicants must provide a copy of acceptable **proof of their legal name and date of birth**, such as a valid driver's license or identification card, with this application, or the application will be rejected. Only original signatures will be accepted, no photocopies or faxes. Form must be legible and completed in ink. Any alterations, crossovers, or whiteouts (including changes with initials) will void this form. Incomplete applications delay processing and will be returned.

SECTION 1 — APPLICANT OR ORGANIZATION INFORMATION *(Enclose Proof of Legal Name/Birthdate CVC 5007)*

TRUE FULL NAME *(LAST, FIRST, MIDDLE OR ORGANIZATION NAME)*

DATE OF BIRTH *(FOR INDIVIDUALS ONLY) (MM/DD/YYYY)*

PHYSICAL ADDRESS *(INCLUDE ST., AVE., RD., CT., ETC.)* | APT./SPACE/STE.#

DRIVER LICENSE/ID CARD NUMBER (*FOR INDIVIDUALS ONLY*)

CITY | COUNTY | STATE | ZIP CODE

MAILING ADDRESS *(IF DIFFERENT FROM PHYSICAL ADDRESS ABOVE)* | APT./SPACE/STE.#

TELEPHONE NUMBER ( )

CITY | COUNTY | STATE | ZIP CODE

SECTION 2 — TYPE OF DISABLED PERSON PARKING PLACARD(S) OR LICENSE PLATES *(Check all that apply.)*

☐ **Permanent DP Parking Placard** *(No Fee)*

☐ **Temporary DP Parking Placard** ***($6.00 Fee)***

☐ **Travel Parking DP Placard** *(No Fee)*

Must already have a DP Parking Placard, Disabled Veteran License Plates, or DP License Plates.

☐ **Disabled Person License Plates** *(No Fee), see Section 3. Can only be assigned to vehicles registered in the name of the qualified person.*

☐ **Disabled Person License Plates Reassignment**, see Section 3

Have you ever been issued DP License Plates, Disabled Veteran License Plates, or a Permanent DP parking placard in California?
☐ Yes ☐ No

If yes, the license plate or DP parking placard number is _____. A doctor's certification is ***not*** *required unless it was cancelled by DMV or is no longer on record, or four replacement permanent DP placards have been issued during the 2-year renewal period.*

SECTION 3 — DISABLED PERSON LICENSE PLATES APPLICANTS *ONLY*: VEHICLE INFORMATION

LICENSE PLATE NUMBER	VEHICLE IDENTIFICATION NUMBER *(VIN)*	VEHICLE MAKE	VEHICLE YEAR

For organizations – the plated vehicle is used exclusively for transporting disabled persons.

Commercial Vehicles – Weight Fee Exemption. I am requesting an exemption from weight fees for the vehicle described above. It weighs less than 8,001 pounds unladen. I understand that this exemption may be used for ONE commercial vehicle only and I do not have this exemption for any other vehicles I own. ☐ Yes ☐ No

SECTION 4 — APPLICANT OR ORGANIZATION REPRESENTATIVE'S CERTIFICATION AND SIGNATURE

I certify that I have read the "Important Information, Disclosures, and Certifications" on page one and I fully understand and take responsibility for the use of the Disabled Person Parking Placard and/or License Plates that are issued to me. I also certify that I am a disabled person per California Vehicle Code (CVC) §295.5 or that I am an authorized representative of the organization involved in the transportation of disabled persons and the vehicle is used for the purpose of transporting those persons per CVC §§5007(a)(3), 22511.55(a)(4). I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

SIGNATURE OF APPLICANT OR ORGANIZATION AUTHORIZED REPRESENTATIVE	DATE	EMAIL ADDRESS *(OPTIONAL)*
X		

SECTION 5 — AUTHORIZED MEDICAL PROVIDER'S INFORMATION

MEDICAL PROVIDER'S NAME *(LAST, FIRST, MIDDLE)*

MEDICAL LICENSE NUMBER

MEDICAL PROVIDER'S ADDRESS *(INCLUDE ST. AVE, RD., CT, ETC.)* | ROOM/SUITE NUMBER

DAYTIME TELEPHONE NUMBER ( )

CITY | COUNTY | STATE | ZIP CODE

IMPORTANT: CONTINUE TO NEXT PAGE
YOUR APPLICATION CANNOT BE PROCESSED WITHOUT PAGES 2 AND 3

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Important: **this is page 3 of the application.**
Both pages 2 and 3 are required in order to process the application.

SECTION 6 — MEDICAL PROVIDER'S CERTIFICATION OF DISABILITY *(Print patient name in space provided below.)*

My patient, _____, suffers from the condition(s) below and, pursuant to CVC §295.5, is eligible for a:
PATIENT NAME

☐ **PERMANENT DP PARKING PLACARD OR LICENSE PLATES**

☐ **TEMPORARY DP PARKING PLACARD**
Until: Month _____ Day _____ Year _____
Cannot exceed six (6) months

☐ **TRAVEL DP PARKING PLACARD**
Until: Month _____ Day _____ Year _____
Cannot exceed 30 days for a CA resident and 90 days for a non-resident

1. ☐ Central visual acuity does not exceed 20/200 in the better eye, with corrective lenses, as measured by the Snellen test, or visual acuity that is greater than 20/200, but with a limitation in the field of vision such that the widest diameter of the visual field subtends an angle not greater than 20 degrees.
2. ☐ A cardiovascular disease to the extent that the person's functional limitations are classified in severity as class III or class IV based upon standards accepted by the American Heart Association.
3. ☐ A lung disease to the extent that forced (respiratory) expiratory volume for one second when measured by spirometry is less than one liter or arterial oxygen tension (pO2) is less than 60 mm/Hg on room air while the person is at rest.

For items 4-8, check the appropriate box(es) and **print a full and legible description** of the illness or disability in Section 6A with enough information on the applicant's disability to meet requirements in state law for certification.

Acceptable descriptions include, but are not limited to: "Parkinson's Disease," "arthritis of ankle and foot," "congestive heart failure," or "diabetes mellitus with peripheral vascular disease." Descriptions such as "trouble walking," "back pain," "weakness," or simply an abbreviation such as "R60.9" are not acceptable. Forms with incomplete or illegible information will be returned.

4. ☐ A diagnosed disease or disorder which substantially impairs or interferes with mobility due to *(complete Section 6A)*:
5. ☐ A severe disability in which the person is unable to move without the aid of an assistive device, which is due to *(complete Section 6A):*
6. ☐ A significant limitation in the use of lower extremities due to *(complete Section 6A)*:
7. ☐ The loss, or loss of the use of one or more lower extremities. Loss of use due to *(complete Section 6A)*:
8. ☐ The loss, or loss of the use of, both hands. Loss of use due to *(complete Section 6A)*:

SECTION 6A— DESCRIPTION OF ILLNESS OR DISABILITY (Not Symptoms) AS NOTED IN 4-8 ABOVE

I certify that I am an authorized and currently state licensed:

☐ **Physician** ☐ **Surgeon** ☐ **Chiropractor** ☐ **Podiatrist**

☐ **Optometrist** ☐ **Physician Assistant** ☐ **Nurse Practitioner** ☐ **Certified Nurse-Midwife**

and

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing information in Sections 5, 6 and 6A is true and correct. I also certify that I will retain information sufficient to substantiate this certification and shall make that information available for inspection by the appropriate regulatory agency overseeing my license at the department's request.

MEDICAL PROVIDER'S SIGNATURE	PRINTED NAME OR STAMP	DATE
X		

DMV USE ONLY

DOCUMENT		PRIOR DP PLACARD/PLATES	☐ OBSERVABLE/UNCONTESTED
CODE	STATE/COUNTRY OF ISSUANCE	SECTION(S) *(CIRCLE)* 2 R/O COMM.	TECHNICIAN ID AND DATELINE STAMP
NUMBER		☐ DCS ATTACHED	