



# APPLICATION FOR DISABILITY PARKING PLACARD OR TAGS

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

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

You may mail this form to DC DMV, Medical Review Services, PO Box 90120 Washington, DC 20090, or fax to 202-673-9908.  
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 (Please check appropriate box):**

- 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 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: \_\_\_\_\_

GOVERNMENT OF THE DISTRICT OF COLUMBIA – DISTRICT DEPARTMENT OF  
TRANSPORTATION  
APPLICATION FOR RESERVED RESIDENTIAL PARKING SPACE  
FOR DISABLED RESIDENT

**License Plate # of Vehicle using space** \_\_\_\_\_

**IMPORTANT NOTICE**

All requested information must be typed or printed in ink and signed before a Notary Public. All questions must be completely answered. Attach additional sheets of paper as necessary. The making of any false statement in this application may result in refusal to approve the reserved residential parking space or, if granted, in revocation of the same; and may subject the offender to penalties prescribed by law. Before completing form, refer to instructions on reverse side.

Disabled License Plate or Permit No. \_\_\_\_\_ Expires \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

(Last)                      (First)                      (Middle)

Address \_\_\_\_\_ Driver Permit No. \_\_\_\_\_

Zip Code \_\_\_\_\_ Ward \_\_\_\_\_ Telephone No. (Res.) \_\_\_\_\_ (Off.) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_

Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Color of Eyes \_\_\_\_\_ Color of Hair \_\_\_\_\_

1. Is the above address a single family dwelling in which you are domiciled and which is your principal place of residence?                      Yes \_\_\_\_\_ No \_\_\_\_\_
2. Are you the operator of the vehicle for which this space is requested?    Yes \_\_\_\_\_ No \_\_\_\_\_
3. Can you utilize any other form of transportation other than this vehicle?    Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, you must provide a clear and concise written explanation. If due to a medical condition, you may be required to submit medical documentation).
4. Is there off-street parking at or adjacent to your residence?    Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, provide a clear and concise written explanation why this parking can not accommodate your needs, including environmental or topographical conditions).
5. Location of and distance from your residence to the nearest available off-street public, private or commercial parking?
6. Under normal conditions, what is the maximum distance you can walk or, if utilized, propel a wheelchair? (Note: You may be required to submit medical documentation). \_\_\_\_\_

I certify that all information furnished in relationship to this application is complete and true to the best of my knowledge, and the reserved space being requested is for my personal use.

Signature of applicant \_\_\_\_\_

\_\_\_\_\_, being duly sworn, deposes and says that she/he is the individual making the foregoing application for a reserved parking space for a disabled resident; that the answers to the foregoing questions and other statements contained in this application are true to the best of her/his own knowledge and belief.

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 200\_ at \_\_\_\_\_.

**Application is for Disabled Individual's information.**

INSTRUCTIONS FOR COMPLETING APPLICATION

Eligibility for a reserved residential parking space is limited to a resident who:

- (1) holds valid special license plates or a permit for a person with a disability issued by the District as a result of having furnished required medical certification of either permanent loss of the use of one or both legs or suffering from a documented qualifying respiratory disease or ailment.\*
- (2) is legally domiciled in a single-family residence in the District of Columbia which is that resident's principal place of residence;
- (3) is the operator of the vehicle for which the reserved space is requested and cannot avail herself or himself of any other form of transportation;
- (4) has no readily available parking within a distance that is reasonably accessible; and
- (5) does not have off-street parking available in the form of a driveway, garage, or private parking space immediately adjacent to or on the premises of the residence.

\*Applicants who were initially issued the special license plates or permit prior to November 1, 1989, maybe required to submit specific detailed medical documentation to recertify continued eligibility. Upon review of this application, you will be notified of any additional medical documentation required.

**MAIL APPLICATION TO: District Department of Transportation, Infrastructure Project Management Administration, Team 2, 55 M Street SE, 4<sup>th</sup> Floor, Washington, DC 20003.**

**FOR OFFICIAL USE ONLY:**

**DDOT:** Does \_\_\_\_\_ does not \_\_\_\_\_ meet preliminary review criteria. By \_\_\_\_\_ Date \_\_\_\_\_

**DMV:** Does \_\_\_\_\_ does not \_\_\_\_\_ meet medical requirements. Category \_\_\_\_\_ By \_\_\_\_\_

**Comments:**

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**Rulemaking: Proposed** \_\_\_\_\_ **DCR** \_\_\_\_\_ **Date** \_\_\_\_\_ **Finals** \_\_\_\_\_ **DCR** \_\_\_\_\_ **Date** \_\_\_\_\_

**Space No.** \_\_\_\_\_ **Shop Order No** \_\_\_\_\_ **Date Submitted** \_\_\_\_\_ **Dated Installed** \_\_\_\_\_