Reset Form

APPLICATION FOR DISABILITY PLATE OR PARKING PLACARD

State Form 42070 (R13 / 11-13)
Approved by State Board of Accounts, 2013
INDIANA BUREAU OF MOTOR VEHICLES

Bureau of Motor Vehicles
Winchester Mail Processing Center
PO Box 100
Winchester, IN 47394

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8. Disclosure is voluntary and you will not be penalized for refusal.

INSTRUCTIONS:
1. *Complete in blue or black ink or print form.*
2. *To apply for a disability license plate complete Sections 1 and 2.*
3. *To apply for a disability parking placard complete Sections 1 and 3. If applying by mail for a temporary disability placard, include payment of $5.00 in the form of a check or money order.*
4. *Have your medical practitioner complete Section 4.*
5. *Practitioner's certification is not required for permanent placards issued to corporations, limited liability companies, partnerships, or unincorporated associations that provide transportation to individuals with disabilities or operates programs or facilities for such individuals.*
6. *Applications may be mailed to the Winchester Mail Processing Center, P.O. Box 100, Winchester, IN 47394.*

SECTION 1 - APPLICANT INFORMATION

Name of Applicant *(first, middle, last) (if corporation or agency, list name)*	Social Security Number* or Federal Identification Number	Date of Birth *(mm/dd/yyyy)*

Address *(number and street)*	City	State	ZIP Code

SECTION 2 - APPLICATION FOR DISABILITY LICENSE PLATE

I am eligible to receive a disability license plate because: *(check one)*

- ☐ I meet the definition of "disabled" (to qualify for the license plate) as outlined by Indiana Code 9-18-22-1.
- ☐ I am blind or visually impaired.
- ☐ I represent a corporation, limited liability company, partnership, or unincorporated association that provides transportation for individuals with disabilities or operates programs or facilities for such individuals.
- ☐ The Indiana Bureau of Motor Vehicles has issued me a permanent parking placard.

I swear or affirm under the penalty of perjury that the information in this application is true and correct. It is a Class C misdemeanor to knowingly make false representations to obtain a disability plate.

Signature	Printed Name	Date Signed *(mm/dd/yyyy)*

If the applicant is not the vehicle owner, the vehicle owner must complete the following section.
The applicant must complete section 1 and 2 above.

Name of Vehicle Owner *(first, middle, last) (if corporation or agency, list name)*	Social Security Number* or Federal Identification Number

Address *(number and street)*	City	State	ZIP Code

I swear or affirm under the penalty of perjury that my vehicle regularly transports the applicant.

Signature	Printed Name	Date Signed *(mm/dd/yyyy)*

SECTION 3 - APPLICATION FOR A DISABILITY PARKING PLACARD

I am applying for the following type of disability placard: *(check one)*

☐ New ☐ Renewal ☐ Duplicate

The disability is:

☐ Temporary ☐ Permanent

I am eligible to receive a disability placard because: *(check one)*

- ☐ I meet the definition of "disabled" (to qualify for the placard) as outlined by Indiana Code 9-14-5-1.
- ☐ I am blind or visually impaired.
- ☐ I represent a corporation, limited liability company, partnership, or unincorporated association that provides transportation for individuals with disabilities or operates programs or facilities for such individuals.

I swear or affirm under the penalty of perjury that the information in this application is correct. It is a Class C misdemeanor to knowingly make false representations to obtain a disability placard.

Signature	Printed Name	Date Signed *(mm/dd/yyyy)*

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SECTION 4A - PRACTITIONER'S CERTIFICATION OF SEVERELY LIMITED MOBILITY

Name of Applicant *(first, middle, last)*	Date of Birth *(mm/dd/yyyy)*

I certify that the applicant meets the qualifications as outlined by Indiana law to receive a disability placard and/or license plate. This disability is:

☐ Permanent ☐ Temporary and is expected to end on: / / *(mm/dd/yyyy)*

I am:

☐ A physician with a valid and unrestricted license to practice medicine in Indiana.

☐ A physician with a valid and unrestricted license to practice medicine from a state other than Indiana. *(Placards only)*

☐ A physician who is a commissioned medical officer of the United States Armed Forces or the United States Public Health Service. *(Placards only)*

☐ An advanced practice nurse with a valid and unrestricted license under Indiana Code 25-23. *(Placards only)*

☐ A chiropractor with a valid and unrestricted license under Indiana Code 25-10-1. *(Placards only)*

☐ A podiatrist with a valid and unrestricted license under Indiana Code 25-29-1. *(Placards only)*

☐ A physician who is a medical officer of the United States Department of Veterans Affairs. *(Placards only)*

Signature	Printed Name	Date Signed *(mm/dd/yyyy)*

Telephone Number ( )	License Number

Address *(number and street)*	City	State	ZIP Code

SECTION 4B - PRACTITIONER'S CERTIFICATION OF BLINDNESS OR VISUAL IMPAIRMENT

Name of Applicant *(first, middle, last)*	Date of Birth *(mm/dd/yyyy)*

I certify that the applicant is blind or visually impaired as defined by Indiana law and may receive a disability placard and/or license plate. This condition is:

☐ Permanent ☐ Temporary and is expected to end on: / / *(mm/dd/yyyy)*

I am:

☐ An ophthalmologist with a valid and unrestricted license to practice in Indiana

☐ An optometrist with a valid and unrestricted license to practice in Indiana

Signature	Printed Name	Date Signed *(mm/dd/yyyy)*

Telephone Number ( )	License Number