555 Wright Way
Carson City, NV 89711
Reno/Sparks/Carson City (775) 684-4DMV (4368)
Las Vegas area (702) 486-4DMV (4368)
Rural Nevada or Out of State (877) 368-7828
Fax (775) 684-4797
www.dmvnv.com

DISABLED PERSONS LICENSE PLATES AND/OR PLACARDS APPLICATION

NRS 482.384

First time applications for Disabled Persons license plates or motorcycle license plates must be made in person. In order to apply for disabled persons license plates or disabled motorcycle stickers your name must appear on the vehicle certificate of registration and provide your current Nevada evidence of insurance. If your vehicle is currently registered, you have the option of maintaining your current vehicle registration expiration date, or renewing for a full twelve (12) month period. Credit for any unused portion of your current registration is transferable to your disabled license plate registration. In applicable counties, if you are renewing for a full 12-month period, and your previous emissions test was obtained more than 90 days ago, the vehicle must be re-tested prior to registration. **You must have a permanent disability to qualify for disabled persons license plates *(see description below)*.** If the Physician's portion is not completed in full, this application cannot be processed.

You may select either license plates and one (1) placard, or two (2) placards. If applying for license plates you must go to your local DMV and provide your current Nevada evidence of insurance.

☐ Disabled License Plates (permanent disability only) Disabled Placard(s) (no fee for placards) ☐ One ☐ Two
☐ Disabled Motorcycle Plates (permanent disability only) Disabled Motorcycle Sticker (moderate or temporary) ☐ One ☐ ____

Please Print or Type

Full Legal Name
(Disabled Person) _____
First Middle Last

Nevada Driver's License or Identification Card Number _____ Date of Birth ____/____/____

Physical Address _____
Address City State Zip Code

Mailing Address _____
Address City State Zip Code

County of Residence _____ Telephone No _____ ***E-Mail Address*** _____

Signature of Applicant _____ Date _____

A LICENSED PHYSICIAN MUST COMPLETE THIS PORTION*

As a Physician for the above-named patient, I hereby certify that the applicant:

1. _____ Cannot walk two hundred feet without stopping to rest.
2. _____ Cannot walk without the use of a brace, cane, crutch, wheelchair or prosthetic, or other assistive device, or another person.
3. _____ Has a cardiac condition to the extent that functional limitations are classified as Class III or Class IV according to standards adopted by the American Heart Association.
4. _____ Is restricted by a lung disease to such an extent that the person's forced expiratory volume for 1 second, when measured by a spirometer, is less than 1 liter, or the arterial oxygen tension is less than 60 millimeters of mercury on room air while the person is at rest.
5. _____ Is severely limited in his/her ability to walk because of an arthritic, neurological, or orthopedic condition.
6. _____ Has a visual disability.
7. _____ Uses portable oxygen.

I further certify that my patient's condition is a:

☐ **Temporary Disability** (6 months or less) must indicate length of time not to exceed 6 months *beginning* _____ and *ending* _____

☐ **Moderate Disability** (reversible but disabled longer than 6 months)
Must indicate length of time not to exceed 2 years *beginning* _____ and *ending* _____

☐ **Permanent Disability** (irreversible, permanently disabled in his/her ability to walk, certification is valid indefinitely).

Please print or type and complete in full:

Physician's Name _____ Physician's License No. _____
First Middle Last

Mailing Address _____ Telephone No. _____
Address City State Zip Code

Physician's Signature _____ Date _____

 * Physicians Assistant Certified (PA-C) or Advanced Practice Nurse (APN) are not authorized to complete this document.