VERMONT

State of Vermont
DEPARTMENT OF MOTOR VEHICLES
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Agency of Transportation

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VERMONT TEMPORARY DISABLED PARKING PLACARD APPLICATION AND MEDICAL FORM

SECTION A - TO BE COMPLETED BY APPLICANT

Name: _____
Last First Middle

Mailing Address: _____
Street or Box Number

_____
City State Zip

Legal Address: _____
Street, Road, Highway

Date of Birth: ____ - ____ - _____ Gender: ☐ Male ☐ Female

Social Security Number: _____ - _____ - _____

Vermont Driver's License (if applicable): _____

I make this application under provisions of 23 VSA § 304(f) and I am aware of the limitations of the use of this parking placard by other than disabled persons.

I certify that the statements herein are true. This declaration is made under the penalties of 23 VSA § 202.

_____ _____
Signature of Applicant Date Signed

SECTION B - TO BE COMPLETED BY LICENSED PHYSICIAN, CERTIFIED PHYSICIAN'S ASSISTANT OR LICENSED ADVANCED PRACTICE REGISTERED NURSE

❑ This is to certify that the person named above is temporarily disabled with an ambulatory handicap.

❑ I recommend that the temporary placard be valid until: ____ ____
Month Year

Note: 6 months maximum – <u>may not be renewed</u>

_____ _____
Physician/Physician Asst./LAPRN Name (Print) License Number

_____ _____
Physician/Physician Asst./LAPRN Signature Date Signed

FOR DEPARTMENT USE ONLY

❑ 225 ❑ 227 ❑ 231 ❑ 232 ❑ 233

PID: _____

Rater #: _____

Temporary Placard Expires: ____ / ____
MM YY

Placard Number: ____ ____ ____ ____

Audit Line

TA-VL-38 (d) **INTERNET** 8/06 JTB