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
www.dmvnv.com

APPLICATION FOR DISABLED PERSONS LICENSE PLATES AND/OR PLACARDS

NRS 482.384

☐ Disabled Plates *(permanent disability only)* Disabled Placard(s) ☐ One ☐ Two
You may select either plates and one (1) placard, or two (2) placards.

Disabled Motorcycle Sticker ☐ One ☐ Other _____

First time applications for a Disabled Persons license plate or motorcycle sticker must be made in person.

In order to apply for disabled persons license plates or disabled motorcycle stickers(s) your name must appear on the vehicle registration certificate. 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 evidence of compliance with emissions standards was obtained more than 90 days ago, the vehicle must be re-inspected prior to registration. **You must have a permanent disability to qualify for Disabled Persons license plates *(see description below).***

Please Print or Type

Applicants Name_____ ____/____/____
(Disabled Person) First Middle Last Date of Birth

Address_____
Address City State Zip Code

County of Residence _____ Nevada DL or ID No. _____ Daytime Telephone No (_____)_____

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 other device or another person.
3. _____ Has a cardiac condition to the extent that functional limitations are classified as a Class III or Class IV according to standards adopted by the American Heart Association.
4. _____ Is restricted by a lung disease.
5. _____ Is severely limited in his/her ability to walk because of an arthritic, neurological, or orthopedic condition.
6. _____ Is visually handicapped.
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* _____ *ending* _____

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

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

Please Print or Type

Physician's Name_____

Mailing Address _____
Address City State Zip Code

Physicians License Number _____ Telephone No (_____)_____

Physicians Signature _____ Date _____

* **Physicians Assistant Certified (PCN) or Advanced Practioners Nurse (APN) are not authorized to complete this document.**