555 Wright Way
Carson City, NV 89711
Reno/Carson City (775) 684-4DMV (4368)
Las Vegas (702) 486-4DMV (4368)
Fax (775) 684-4797
dmv.nv.gov

DISABLED PERSONS LICENSE PLATES AND/OR PLACARDS APPLICATION
NRS 482.384 & 484B.467

First time applications for Disabled Persons license plates, motorcycle or moped 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, APRN's, or Physician's Assistant portion is not completed in full, this application cannot be processed.

Erasures or whiteout will void this form.

Applicant Must Complete this Portion

You may select two (2) placards, or license plates and one (1) placard. 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 Motorcycle Plate (permanent disability only)
☐ Disabled Moped Plate (permanent disability only)

Disabled Placards(s) (no fee for placards) ☐ One ☐ Two
Disabled Motorcycle Sticker (permanent or moderate) ☐
Disabled Moped Sticker (permanent or moderate) ☐

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 _____

I declare under penalty of perjury that the information on this application is true and correct. I hereby make application for a Disabled License Plate and/or placard(s). I have read and understand the conditions under which these license plate(s) and/or placards are to be issued and agree to comply with NRS 484B.467.

_____ _____
Signature of Applicant Date

Please Print or Type Full Legal Name
(Disabled Applicant) _____
First Middle Last

A LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT (PA), ADVANCED PRACTICE REGISTERED NURSE (APRN), OCCUPATIONAL THERAPIST (OT) OR PHYSICAL THERAPIST (PT) MUST COMPLETE THIS PORTION.

Please print or type and complete in full:

Please check one: ☐ Licensed Physician ☐ Advanced Practice Registered Nurse (APRN) ☐ Physician's Assistant

☐ Occupational Therapist ☐ Physical Therapist

Physician's, PA's, APRN's, OT's or PT's: Printed Name:

_____
First Middle Last

Physician's, APRN's, PA's, OT's or PT's : License No. _____ State _____

Mailing Address _____
Address City State Zip Code Telephone No.

As a Physician, PA, APRN, OT or PT 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.

Physician's, PA's, APRN's, OT's or PT's Signature _____

Date _____

FOR OFFICE USE ONLY

Plate/Placard Number (s) _____ _____

DMV Tech Initials _____ Date Issued _____