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# APPLICATION FOR DISABLED PERSONS LICENSE PLATES AND/OR PLACARDS

**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 ____/____/____

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 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 _____
First Middle Last

Mailing Address _____
Address City State Zip Code

Physicians License Number _____ Telephone No _____

Physician's Signature _____ Date _____

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