



555 Wright Way
Carson City, NV 89711
Reno/Sparks/Carson City (775) 684-4DMV (4368)
Las Vegas area (702) 486-4DMV (4368)
Fax (775) 684-4797
dmvnv.com

DISABLED PERSONS LICENSE PLATES AND/OR PLACARDS APPLICATION
NRS 482.384

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, APRN, or Physician 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 Placard(s) (no fee for placards)
Disabled Motorcycle Sticker (permanent/moderate)
Disabled Moped Sticker (permanent/moderate)
One
Two

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 understand that a violation of the use of disabled person license and placards is a misdemeanor violation of NRS 484B.467 and punishable by fines.

Signature of Applicant

Date

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

**A LICENSED PHYSICIAN, ADVANCED PRACTICE REGISTERED NURSE (APRN), OR PHYSICIAN ASSISTANT MUST COMPLETE THIS PORTION**

**Please print or type and complete in full:**

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

Physicians, APRN's, or Physician Assistant: Printed Name:

\_\_\_\_\_  
First Middle Last

Physician, APRN, or Physician Assistant: License No. \_\_\_\_\_ State \_\_\_\_\_

Mailing Address \_\_\_\_\_ Telephone No. \_\_\_\_\_  
Address City State Zip Code

**As a Physician, APRN, Physician Assistant 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, APRN, or Physician Assistant: Signature \_\_\_\_\_

Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

Plate/Placard Number(s) \_\_\_\_\_

DMV Tech Initials \_\_\_\_\_ Date Issued \_\_\_\_\_