pennsylvania
DEPARTMENT OF TRANSPORTATION
www.dmv.pa.gov

PERSON WITH DISABILITY PARKING PLACARD APPLICATION NO FEE REQUIRED

SEE REVERSE SIDE FOR INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

FOR DEPARTMENT USE ONLY

Bureau of Motor Vehicles • P.O. Box 68268 • Harrisburg, PA 17106-8268

CHECK (✓) APPROPRIATE BLOCKS BELOW Severely Disabled Veteran Temporary Placard RENEWAL REQUEST - (For Permanent Placards Only) REPLACEMENT REQUEST - PLACARD DCARD Defaced Lost Stolen Never Recommendation	Received PREV rriage Divor ISABILITY - No hoto ID# D# sinor child (under 18 dy care or control of ant NEW JERSEY, DEL I THEIR SCOPE OF cument knowing it an \$10,000 or impr the reverse side of this application qual	State State State AWARE, M. PRACTICE to have beginsonment on this lify R 2 B 2	Dither: Sting an out-of-state address, Date of Birth Zip Code The child's natural parents (person in adult child or a spouse may sign on adult child or a spouse may sign on attended or counterfeited, of not more than five years, or both. UNCORRECTED UNCORRECTED UNCORRECTED UNCORRECTED			
REPLACEMENT REQUEST - PLACARD Defaced Lost Stolen Never Record CHANGE OF ADDRESS - Complete Sections A and E. NOTE: Notarization is not required. CHANGE OF NAME - Complete Sections A and E. Check here to indicate reason for change of name: Marria CHANGE OF NAME - Complete Sections A and E. Check here to indicate reason for change of name: Marria CHANGE OF NAME - Complete Sections A and E. Check here to indicate reason for change of name: Marria CHANGE OF NAME - Complete Sections A and E. Check here to indicate reason for change of name: Marria CHANGE OF NAME - Change OF NAME	ISABILITY - Notation of the control	State State State AWARE, M. PRACTICE to have beginsonment on this lify R 2 B 2	Dither: Sting an out-of-state address, Date of Birth Zip Code The child's natural parents (person in adult child or a spouse may sign on adult child or a spouse may sign on attended or counterfeited, of not more than five years, or both. UNCORRECTED UNCORRECTED UNCORRECTED UNCORRECTED			
CHANGE OF ADDRESS - Complete Sections A and E. NOTE: Notarization is not required. CHANGE OF NAME - Complete Sections A and E. Check here to indicate reason for change of name: Married CHANGE OF NAME - Complete Sections A and E. Check here to indicate reason for change of name: Married CHANGE OF NAME - Complete Sections A and E. Check here to indicate reason for change of name: Married CHANGE OF NAME - Complete Sections A and E. Check here to indicate reason for change of name: Married CHANGE OF NAME - CHANGE O	ISABILITY - Notation of the control	State State State AWARE, M. PRACTICE to have beginsonment on this lify R 2 B 2	Dither: Sting an out-of-state address, Date of Birth Zip Code The child's natural parents (person in adult child or a spouse may sign on adult child or a spouse may sign on attended or counterfeited, of not more than five years, or both. UNCORRECTED UNCORRECTED UNCORRECTED UNCORRECTED			
CHANGE OF NAME - Complete Sections A and E. Check here to indicate reason for change of name: Marria A PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON OF PAGE AND ADDRESS OF PERSON OF PERSO	hoto ID# D# hinor child (under 18) by care or control of ant NEW JERSEY, DEL I THEIR SCOPE OF cument knowing it an \$10,000 or impr he reverse side of this application qua	State State State AWARE, MAPRACTICE to have been somment on this R 2 L 2 B 2 B 2	Zip Code ARYLAND, WEST VIRGINIA OR E. WARNING: Altering or forging a en altered, forged or counterfeited, foot more than five years, or both. UNCORRECTED UNCORRECTED IO/ IO/ IO/ IO/ IO/ IO/ IO/ IO/ IO/ IO			
PERSON WITH DISABILITY INFORMATION - LIST NAME AND ADDRESS OF PERSON WITH DISYOU must also complete and attach Form MV-8. Last Name (or Full Business Name) First Name Middle Name PA DL/Phor Bus. ID Street Address City Email Address NOTE: If you are the parent or adult charged by law with the natural parent's rights, duties and responsibilities acting on behalf of a min loco-parentis), you must complete the information below. In addition, a parent, including an adoptive or foster parent who has custody behalf of the child, adult child or spouse (applicant) provided the applicant meets eligibility requirements (1) through (8). Name of Parent, Person in Loco Parentis or Spouse Street Address City CERTIFICATION FROM A HEALTH CARE PROVIDER LICENSED OR CERTIFIED IN PA OR A CONTIGUOUS STATE (NEW YORK, NOHIO). THIS SECTION MUST BE COMPLETED IN FULL. HEALTH CARE PROVIDERS MAY ONLY CERTIFY DISABILITIES WITHIN document issued by the Department, such as a disabled person parking placard, or possessing, using or displaying such a doc is a misdemeanor of the first degree pursuant to the Vehicle Code, 75 Pa.C.S. Section 7122, punishable by a fine of not more the application under "Eligibility Requirements": List Reason Code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the individual's visual acuity by completing the chart to the right: Temporary placards are only issued for a period of time not to exceed six months. If the applicant requires additional time at the placard issued, the applicant must be recertified by a health care Provider's Signature	hoto ID# D# hinor child (under 18) by care or control of ant NEW JERSEY, DEL I THEIR SCOPE OF cument knowing it an \$10,000 or impr he reverse side of this application qua	State State State AWARE, MAPRACTICE to have been somment on this R 2 L 2 B 2 B 2	Zip Code ARYLAND, WEST VIRGINIA OR E. WARNING: Altering or forging a en altered, forged or counterfeited, foot more than five years, or both. UNCORRECTED UNCORRECTED IO/ IO/ IO/ IO/ IO/ IO/ IO/ IO/ IO/ IO			
Last Name (or Full Business Name) Last Name (or Full Business Name) Street Address City Email Address NOTE: If you are the parent or adult charged by law with the natural parent's rights, duties and responsibilities acting on behalf of a min loco-parentis), you must complete the information below. In addition, a parent, including an adoptive or foster parent who has custody behalf of the child, adult child or spouse (applicant) provided the applicant meets eligibility requirements (1) through (8). Name of Parent, Person in Loco Parentis or Spouse Street Address City CERTIFICATION FROM A HEALTH CARE PROVIDER LICENSED OR CERTIFIED IN PA OR A CONTIGUOUS STATE (NEW YORK, NOHIO). THIS SECTION MUST BE COMPLETED IN FULL. HEALTH CARE PROVIDERS MAY ONLY CERTIFY DISABILITIES WITHIN document issued by the Department, such as a disabled person parking placard, or possessing, using or displaying such a doc is a misdemeanor of the first degree pursuant to the Vehicle Code, 75 Pa.C.S. Section 7122, punishable by a fine of not more the application under "Eligibility Requirements": List Reason Code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the individual's visual acuity by completing the chart	hoto ID# D# sinor child (under 18 dy care or control of ant NEW JERSEY, DEL I THEIR SCOPE OF cument knowing it an \$10,000 or imprese reverse side of this application quality.)	State State AWARE, M. PRACTICE to have been soment on this lify R 2	Date of Birth Zip Code the child's natural parents (person in adult child or a spouse may sign on Zip Code ARYLAND, WEST VIRGINIA OR: WARNING: Altering or forging a en altered, forged or counterfeited, for more than five years, or both. UNCORRECTED UNCORRECTED UNCORRECTED UNCORRECTED			
B CERTIFICATION FROM A HEALTH CARE PROVIDER LICENSED OR CERTIFIED IN PA OR A CONTIGUOUS STATE (NEW YORK, NOHO). This SECTION MUST BE COMPLETED IN FULL. HEALTH CARE PROVIDERS May ONLy CERTIFY DISABILITIES WITHIN document issued by the Department, such as a disabled person parking placard, or possessing, using or displaying such a doc is a misdemeanor of the first degree pursuant to the Vehicle Code, 75 Pa.C.S. Section 7122, punishable by a fine of not more than 1 fr eason code #4 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the individual's visual acuity by completing the chart to the right: Health Care Provider's Signature Leath Reason Code #4 is leath Care Provider's Printed Name Health Care Provider's Printed Name Middle Name Middle Name PA DL/Phor Bus. ID City City City City City City City CERTIFICATION FROM A HEALTH CARE PROVIDER LICENSED OR CERTIFIED IN PA OR A CONTIGUOUS STATE (NEW YORK, NO ALLY CERTIFY DISABILITIES WITHIN COMMENT OF PROVIDERS MAY ONLY CERTIFY DISABILITIES WITHIN DISA	D# ninor child (under 18 dy care or control of ant NEW JERSEY, DEL I THEIR SCOPE OF cument knowing it an \$10,000 or imprese reverse side of this application quality.	State AWARE, MAPRACTICE to have beed isonment of this R 2 L 2 B 2	Zip Code the child's natural parents (person in adult child or a spouse may sign on Zip Code ARYLAND, WEST VIRGINIA OR E. WARNING: Altering or forging a en altered, forged or counterfeited, frot more than five years, or both. UNCORRECTED O/ O/ O/ O/			
B NOTE: If you are the parent or adult charged by law with the natural parent's rights, duties and responsibilities acting on behalf of a min loco-parentis), you must complete the information below. In addition, a parent, including an adoptive or foster parent who has custody behalf of the chilid, adult child or spouse (applicant) provided the applicant meets eligibility requirements (1) through (8). Name of Parent, Person in Loco Parentis or Spouse Street Address City CERTIFICATION FROM A HEALTH CARE PROVIDER LICENSED OR CERTIFIED IN PA OR A CONTIGUOUS STATE (NEW YORK, NOHIO). THIS SECTION MUST BE COMPLETED IN FULL. HEALTH CARE PROVIDERS MAY ONLY CERTIFY DISABILITIES WITHIN document issued by the Department, such as a disabled person parking placard, or possessing, using or displaying such a doc is a misdemeanor of the first degree pursuant to the Vehicle Code, 75 Pa.C.S. Section 7122, punishable by a fine of not more that application under "Eligibility Requirements": List Reason Code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the bype of device used: Temporary placards are only issued for a period of time not to exceed six months. If the applicant requires additional time at the placard issued, the applicant must be recertified by a health care provider. Health Care Provider's Printed Name	NEW JERSEY, DEL I THEIR SCOPE OF cument knowing it ian \$10,000 or impr ie reverse side of t his application qua	State AWARE, MAPRACTICE to have beed isonment of this R 2 L 2 B 2	the child's natural parents (person in adult child or a spouse may sign on Zip Code ARYLAND, WEST VIRGINIA OR WARNING: Altering or forging a en altered, forged or counterfeited, frot more than five years, or both. UNCORRECTED UNCORRECTED O/ O/ O/			
NOTE: If you are the parent or adult charged by law with the natural parent's rights, duties and responsibilities acting on behalf of a min loco-parentis), you must complete the information below. In addition, a parent, including an adoptive or foster parent who has custody behalf of the child, adult child or spouse (applicant) provided the applicant meets eligibility requirements (1) through (8). Name of Parent, Person in Loco Parentis or Spouse Relationship to Applicant	NEW JERSEY, DEL I THEIR SCOPE OF cument knowing it ian \$10,000 or impr ie reverse side of t his application qua	State AWARE, M. PRACTICE to have bee isonment o his R 2 B 2	Zip Code ARYLAND, WEST VIRGINIA OR E. WARNING: Altering or forging a en altered, forged or counterfeited, of not more than five years, or both. UNCORRECTED UNCORRECTED UNCORRECTED UNCORRECTED			
Street Address City CERTIFICATION FROM A HEALTH CARE PROVIDER LICENSED OR CERTIFIED IN PA OR A CONTIGUOUS STATE (NEW YORK, NOHIO). THIS SECTION MUST BE COMPLETED IN FULL. HEALTH CARE PROVIDERS MAY ONLY CERTIFY DISABILITIES WITHIN document issued by the Department, such as a disabled person parking placard, or possessing, using or displaying such a doc is a misdemeanor of the first degree pursuant to the Vehicle Code, 75 Pa.C.S. Section 7122, punishable by a fine of not more that I hereby certify that the person with the disability listed above is under my care and has the following condition listed on the application under "Eligibility Requirements": List Reason Code # Here (NOTE: Only those conditions listed on the reverse side of the an applicant for a person with disability placard.) NOTE: If reason code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the type of device used: Temporary placards are only issued for a period of time not to exceed six months. If the applicant requires additional time at the placard issued, the applicant must be recertified by a health care provider. Health Care Provider's Printed Name Relationship to Applica	NEW JERSEY, DEL I THEIR SCOPE OF cument knowing it ian \$10,000 or impr ie reverse side of t his application qua	State AWARE, M. PRACTICE to have bee isonment o his R 2 B 2	Zip Code ARYLAND, WEST VIRGINIA OR E. WARNING: Altering or forging a en altered, forged or counterfeited, of not more than five years, or both. UNCORRECTED UNCORRECTED UNCORRECTED UNCORRECTED			
B CERTIFICATION FROM A HEALTH CARE PROVIDER LICENSED OR CERTIFIED IN PA OR A CONTIGUOUS STATE (NEW YORK, NOHIO). THIS SECTION MUST BE COMPLETED IN FULL. HEALTH CARE PROVIDERS MAY ONLY CERTIFY DISABILITIES WITHIN document issued by the Department, such as a disabled person parking placard, or possessing, using or displaying such a doc is a misdemeanor of the first degree pursuant to the Vehicle Code, 75 Pa.C.S. Section 7122, punishable by a fine of not more that application under "Eligibility Requirements": List Reason Code # Here (NOTE: Only those conditions listed on the reverse side of the an applicant for a person with disability placard.) NOTE: If reason code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the type of device used: Temporary placards are only issued for a period of time not to exceed six months. If the applicant requires additional time at the placard issued, the applicant must be recertified by a health care provider. Health Care Provider's Printed Name Health Care Provider's Signature	NEW JERSEY, DEL I THEIR SCOPE OF cument knowing it lan \$10,000 or impr e reverse side of t his application qua	AWARE, M. PRACTICE to have bee isonment of this lify R 2 L 2 B 2	ARYLAND, WEST VIRGINIA OR WARNING: Altering or forging a en altered, forged or counterfeited, f not more than five years, or both. UNCORRECTED O/ 0/ 0/			
CERTIFICATION FROM A HEALTH CARE PROVIDER LICENSED OR CERTIFIED IN PA OR A CONTIGUOUS STATE (NEW YORK, NOHIO). THIS SECTION MUST BE COMPLETED IN FULL. HEALTH CARE PROVIDERS MAY ONLY CERTIFY DISABILITIES WITHIN document issued by the Department, such as a disabled person parking placard, or possessing, using or displaying such a doc is a misdemeanor of the first degree pursuant to the Vehicle Code, 75 Pa.C.S. Section 7122, punishable by a fine of not more that application under "Eligibility Requirements": I hereby certify that the person with the disability listed above is under my care and has the following condition listed on the application under "Eligibility Requirements": (NOTE: Only those conditions listed on the reverse side of the an applicant for a person with disability placard.) NOTE: If reason code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the type of device used:	I THEIR SCOPE OF cument knowing it ian \$10,000 or impr re reverse side of t his application qua	AWARE, M. PRACTICE to have bee isonment of this lify R 2 L 2 B 2	ARYLAND, WEST VIRGINIA OR WARNING: Altering or forging a en altered, forged or counterfeited, f not more than five years, or both. UNCORRECTED O/ 0/ 0/			
OHIO). THIS SECTION MUST BE COMPLETED IN FULL. HEALTH CARE PROVIDERS MAY ONLY CERTIFY DISABILITIES WITHIN document issued by the Department, such as a disabled person parking placard, or possessing, using or displaying such a doc is a misdemeanor of the first degree pursuant to the Vehicle Code, 75 Pa.C.S. Section 7122, punishable by a fine of not more that I hereby certify that the person with the disability listed above is under my care and has the following condition listed on the application under "Eligibility Requirements": (NOTE: Only those conditions listed on the reverse side of the an applicant for a person with disability placard.) NOTE: If reason code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the type of device used: Temporary placards are only issued for a period of time not to exceed six months. If the applicant requires additional time at the placard issued, the applicant must be recertified by a health care provider. Health Care Provider's Printed Name Health Care Provider's Signature Health Care Provider's Si	I THEIR SCOPE OF cument knowing it ian \$10,000 or impr re reverse side of t his application qua	PRACTICE to have been sonment of the lifty R 2	E. WARNING: Altering or forging a en altered, forged or counterfeited, if not more than five years, or both. UNCORRECTED 10/ 10/ 10/ 10/			
application under "Eligibility Requirements": List Reason Code # Here (NOTE: Only those conditions listed on the reverse side of the an applicant for a person with disability placard.) NOTE: If reason code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the type of device used: Temporary placards are only issued for a period of time not to exceed six months. If the applicant requires additional time at the placard issued, the applicant must be recertified by a health care provider. Health Care Provider's Printed Name Health Care Provider's Signature	his application qua	lify R 2 L 2 B 2	10/ 10/ 10/			
application under "Eligibility Requirements": List Reason Code # Here (NOTE: Only those conditions listed on the reverse side of the an applicant for a person with disability placard.) NOTE: If reason code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the type of device used: Temporary placards are only issued for a period of time not to exceed six months. If the applicant requires additional time at the placard issued, the applicant must be recertified by a health care provider. Health Care Provider's Printed Name Health Care Provider's Signature	his application qua	lify R 2 L 2 B 2	0/			
NOTE: If reason code #1 is listed above, please indicate the individual's visual acuity by completing the chart to the right: If reason code #4 is listed above, please indicate the type of device used: Temporary placards are only issued for a period of time not to exceed six months. If the applicant requires additional time at the placard issued, the applicant must be recertified by a health care provider. Health Care Provider's Printed Name Health Care Provider's Signature		B 2	0/			
If reason code #4 is listed above, please indicate the type of device used: Temporary placards are only issued for a period of time not to exceed six months. If the applicant requires additional time at the placard issued, the applicant must be recertified by a health care provider. Health Care Provider's Printed Name Health Care Provider's Signature	after the expiration					
the placard issued, the applicant must be recertified by a health care provider. Health Care Provider's Printed Name Health Care Provider's Signature	after the expiration	If reason code #4 is listed above, please indicate the type of device used:				
		of L 2				
Office Street Address City Sta						
	ate Zip Code		Telephone Number ()			
CERTIFICATION BY POLICE OFFICER - Police officer may only certify that the applicant does not have full use of a leg or both legs, or is blind. NOTE: If Section B above is completed, please skip this Section and go on to Section E.						
This is to certify that the person with disability listed above has the condition listed and is entitled to	the use and p	rivileges	of the person with disability			
parking placard. is blind, OR does not have full use of a leg or both legs as evidenced by the use of a: wheelchair walker						
crutches cane/quad cane other prescribed device						
Officer's Printed Name Officer's Signature			Badge Number			
			-			
Office Street Address City Sta	ate Zip Code		Telephone Number ()			
D CERTIFICATION FROM U.S. DEPARTMENT OF VETERANS AFFAIRS REGIONAL OFFICE ADMINISTRATOR (PHILADELPHIA OR PITTSBURGH) OR SERVICE UNIT IN WHICH THE VETERAN SERVED OR A LEGIBLE PHOTOCOPY OF THE APPLICANT'S LETTER OF PROMULGATION, AWARDS LETTER, SINGLE NOTIFICATION, OR SUMMARY OF BENEFITS LETTER.						
This is to certify that the veteran listed above with VA number, has	s a 100% servi	e-conne	cted disability or has the			
following service connected disability reason code number, listed on the reverse side of this NOTE: If reason code #4 is listed, please indicate the type of device used:	is application un	ider "Eligi	bility Requirements."			
Authorized Printed Name and Title: Authorized Signatu	ure:					
In lieu of the U.S. Department of Veterans Affairs Regional Office Administrator certification. I have at	In lieu of the U.S. Department of Veterans Affairs Regional Office Administrator certification, I have attached a legible photocopy of my Letter of Promulgation, Awards Letter, Single Notification Letter, or Summary of Benefits Letter that indicates I have a 100% service-connected disability.					
	I have a 100%					
	I have a 100%					
E NOTARIZATION AND APPLICANT SIGNATURE - Person with disability, natural parent or other author	I have a 100% s					
E NOTARIZATION AND APPLICANT SIGNATURE - Person with disability, natural parent or other author subscribed and sworn to before ME: MONTH DAY YEAR I state that I have read and saffirm that the statements meaning the statements meaning the statements of the statement of the state	I have a 100% sorized person list signed this applicated herein are	cation afte				
E NOTARIZATION AND APPLICANT SIGNATURE - Person with disability, natural parent or other author SUBSCRIBED AND SWORN TO BEFORE ME: MONTH DAY YEAR I state that I have read and affirm that the statements made on or pursuant to this	I have a 100% sorized person list signed this application is	cation afte true and c subject to	o the penalties of 18 Pa.C.S.			
E NOTARIZATION AND APPLICANT SIGNATURE - Person with disability, natural parent or other author SUBSCRIBED AND SWORN TO BEFORE ME: MONTH DAY YEAR I state that I have read and a affirm that the statements m made on or pursuant to this Section 4903 (a)(2) (relating	I have a 100% orized person list signed this application is application is g to false swearing.	cation afte true and c subject to ng), which				
E NOTARIZATION AND APPLICANT SIGNATURE - Person with disability, natural parent or other author SUBSCRIBED AND SWORN TO BEFORE ME: MONTH DAY YEAR I state that I have read and a affirm that the statements m made on or pursuant to this Section 4903 (a)(2) (relating	I have a 100% orized person list signed this application is application is g to false swearing.	cation afte true and c subject to ng), which	o the penalties of 18 Pa.C.S. I shall include punishment of a			
SUBSCRIBED AND SWORN TO BEFORE ME: MONTH DAY SIGNATURE OF PERSON ADMINISTERING OATH SIGNATURE OF PERSON ADMINISTERING OATH SIGNATURE OF PERSON ADMINISTERING OATH SUBSCRIBED AND SWORN TO BEFORE ME: MONTH DAY YEAR I state that I have read and saffirm that the statements m made on or pursuant to this Section 4903 (a)(2) (relating fine not exceeding \$5,000, cor both.	I have a 100% orized person list signed this application is application is g to false swearing.	cation afte true and c subject to ng), which	o the penalties of 18 Pa.C.S. I shall include punishment of a			
SUBSCRIBED AND SWORN TO BEFORE ME: MONTH DAY YEAR I state that I have read and saffirm that the statements made on or pursuant to this Section 4903 (a)(2) (relating fine not exceeding \$5,000, or both.	I have a 100%: prized person lis signed this applic made herein are his application is g to false sweari or to a term or in	cation afte true and c subject t ng), which nprisonme	o the penalties of 18 Pa.C.S. I shall include punishment of a cent of not more than two years,			
SUBSCRIBED AND SWORN TO BEFORE ME: MONTH DAY SIGNATURE OF PERSON ADMINISTERING OATH	I have a 100%: prized person lis signed this applic made herein are his application is g to false sweari or to a term or in	cation afte true and c subject to ng), which	o the penalties of 18 Pa.C.S. I shall include punishment of a cent of not more than two years,			

INSTRUCTIONS

- 1. Permanent Placard Complete Sections A, B or C (NOT BOTH) and E. **NOTE:** Individuals should list their PA Driver's License (PA DL) or Photo ID# in the space provided. Businesses should list their Business ID# (Bus. ID) where indicated (i.e. E.I.N.).
- 2. Severely Disabled Veteran Placard Complete Sections A, D and E.
- 3. Temporary Placard Complete Sections A, B and E. **NOTE:** Only licensed health care providers* may certify disabilities for temporary placards. **Temporary placards may be issued for a period up to six months and may not be extended for an additional period of time.** When additional time is needed, a new application must be completed and certified by a health care provider. In addition, please list your previous placard number.
- 4. Renewal Request Complete Sections A and E. NOTE: Notarization is not required.
- 5. Replacement Request Indicate if applying for a replacement placard or ID card. Please check reason for replacement; Lost, Stolen, Defaced or Never Received. List your previous placard number and complete Sections A and E. NOTE: If product was not received within 90 days, please check the "Never Received" box or if product was not received for over 90 days please check the "Lost" box.
- 6. Change of Address Complete Sections A and E. NOTE: Notarization is not required.
- 7. Change of Name Complete Sections A and E. Check the block on the front of this application to indicate reason for change of name. **NOTE: Notarization is not required.**
- * Health Care Provider is defined as a physician, chiropractor, optometrist, podiatrist, physician assistant, or a certified registered nurse practitioner licensed or certified in Pennsylvania or a contiguous state. Health care providers may only certify disabilities within their scope of practice.

		Benefits
Applicant: (1) is blind. (2) does not have full use of an arm or both arms. (3) cannot walk 200 feet without stopping to rest. (4) cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistive device. (5) is restricted by lung disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter or the arterial oxygen tension is less than 60 MM/HG on room air at rest. (6) uses portable oxygen. (7) has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association. (8) is severely limited in their ability to walk due to an arthritic, neurological or orthopedic condition. NOTE: If you are the parent or adult charged by law with the natural parent's rights, duties, and responsibilities, acting on behalf of a minor child (under 18) in place of the child's natural parents (person in loco-parentis), complete the appropriate information on the front side of this application. In addition, a parent, including an adoptive or foster parent who has custody, care, or control of the child or adult child or a spouse, may sign on behalf of the child, adult child, or spouse (applicant) provided the person with disability meets eligibility requirements (1) through (8).	 (1) A passenger vehicle or truck with a registered gross weight of not more than 14,000 lbs. (2) The placard is required to be displayed when the vehicle is parked in areas designated for use by persons with disability only and must not be displayed when the vehicle is being operated on the highway. NOTE: Organizations that operate a passenger vehicle to transport persons with disabilities must supply the Department with the following: a) A notarized statement of how the placard will be used and the type of services that will be provided. b) The weekly or monthly number of hours that the services are provided. c) The make of the vehicle(s), including the title number, vehicle identification number and registration plate number. The vehicle(s) must be titled in the name of the organization and must be a passenger vehicle. d) The number of placards required: (Organizations may not be issued more than eight placards in the organization's name.) 	 (1) Parking permitted in spaces designated for disabled persons and for 60 minutes in excess of legal parking period except where local ordinances or police regulations provide for the accommodation of heavy traffic during morning, afternoon or evening hours. (2) Upon request of a person with disability, local authorities may erect on the highway as close as possible to the person's residence a sign(s) indicating that the place is reserved for the person with disability, that no one else may park there unless a person with disability plate or placard is displayed and that any unauthorized person parking there will be subject to a fine.
(1) 100% service-connected disability certified by the U.S. Department of Veterans Affairs (Pittsburgh or Philadelphia) or service unit in which the veteran served or as shown on the applicant's Letter of Promulgation, Awards Letter, Single Notification Letter, or Summary of Benefits Letter.	Same as 1 and 2 above for Person with Disability Placard.	Same as above for Person with Disability Placard.
	 (2) does not have full use of an arm or both arms. (3) cannot walk 200 feet without stopping to rest. (4) cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistive device. (5) is restricted by lung disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter or the arterial oxygen tension is less than 60 MM/HG on room air at rest. (6) uses portable oxygen. (7) has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association. (8) is severely limited in their ability to walk due to an arthritic, neurological or orthopedic condition. NOTE: If you are the parent or adult charged by law with the natural parent's rights, duties, and responsibilities, acting on behalf of a minor child (under 18) in place of the child's natural parents (person in loco-parentis), complete the appropriate information on the front side of this application. In addition, a parent, including an adoptive or foster parent who has custody, care, or control of the child or adult child or a spouse, may sign on behalf of the child, adult child, or spouse (applicant) provided the person with disability meets eligibility requirements (1) through (8). (1) 100% service-connected disability certified by the U.S. Department of Veterans Affairs (Pittsburgh or Philadelphia) or service unit in which the veteran served or as shown on the applicant's Letter of Promulgation, Awards Letter, Single Notification 	(2) does not have full use of an arm or both arms. (3) cannot walk 200 feet without stopping to rest. (4) cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistive device. (5) is restricted by lung disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter or the arterial oxygen tension is less than 60 MM/HG on room air at rest. (6) uses portable oxygen. (7) has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association. (8) is severely limited in their ability to walk due to an arthritic, neurological or orthopedic condition. NOTE: If you are the parent or adult charged by law with the natural parents' rights, duties, and responsibilities, acting on behalf of a minor child (under 18) in place of the child's natural parents (person in loco-parentis), complete the appropriate information on the front side of this application. In addition, a parent, including an adoptive or foster parent who has custody, care, or control of the child or adult child or a spouse, may sign on behalf of the child, adult child, or spouse (applicant) provided the person with disability meets eligibility requirements (1) through (8).

Use of Person with Disability and Severely Disabled Veteran Placards:

- . Parking in a designated persons with disability parking space is only permitted with this parking placard when the vehicle is being used for the transportation of the person for which the parking placard was issued.
- . Any vehicle lawfully displaying a parking placard will qualify for parking in areas designated only for use by persons with a disability. **NOTE:** This parking placard can not be used to park where parking is prohibited.

Send completed application to: PennDOT, Bureau of Motor Vehicles, P.O. Box 68268, Harrisburg, PA 17106-8268