



APPLICATION FOR DISABILITY PLATE OR PARKING PLACARD

State Form 42070 (R9 / 1-11)
INDIANA BUREAU OF MOTOR VEHICLES

BUREAU OF MOTOR VEHICLES
Winchester Mail Processing Center
PO Box 100
Winchester, IN 47394

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8. Disclosure is voluntary and you will not be penalized for refusal.

- INSTRUCTIONS:**
1. Complete Section 1 to apply for a disability plate.
 2. Complete Section 2 to apply for a disability parking placard.
 3. Have your medical practitioner complete the certification in Section 3A if your application is based on a severe restriction in mobility due to a pulmonary or cardiovascular disability, arthritic condition, or orthopedic or neurological impairment.
 4. Have your medical practitioner complete the certification in Section 3B if your application is based on blindness or visual impairment.

APPLICANT INFORMATION

Name of applicant (first, middle, last) (if corporation or agency, list name)		Social Security Number* or Federal Identification Number		Date of birth (mm/dd/yyyy)	
Address (number and street)			City	State	ZIP Code

SECTION 1 - APPLICATION FOR DISABILITY LICENSE PLATE

I have a disability that qualifies for a disability plate because (check one):

- I have a permanent disability that requires the use of a wheelchair, walker, braces, or crutches.
- I have permanently lost the use of one or both legs.
- I am severely and permanently restricted in mobility due to a pulmonary or cardiovascular disability, arthritic condition, or orthopedic or neurological impairment.
- I am blind or visually impaired.
- The Indiana Bureau of Motor Vehicles has issued me a permanent parking placard.

I swear or affirm under the penalty of perjury that the information in this application is true and correct. It is a Class C misdemeanor to knowingly make false representations to obtain a disability plate.

Signature	Printed Name	Date Signed (mm/dd/yyyy)
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If the applicant is not the vehicle owner, the vehicle owner must complete the following section.

Name of vehicle owner (first, middle, last) (if corporation or agency, list name)		Social Security Number*	
Address (number and street)		City	State ZIP Code

I swear or affirm under the penalty of perjury that my vehicle regularly transports the applicant.

Signature	Printed Name	Date Signed (mm/dd/yyyy)
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SECTION 2 - APPLICATION FOR A DISABILITY PARKING PLACARD

I am applying for the following type of disability placard (check one):

- New
- Renewal
- Additional/Replacement

The disability is (check one):

- Temporary
- Permanent

I am qualified to receive a disability placard because (check one):

- I have a temporary or permanent disability that requires the use of a wheelchair, walker, braces, or crutches.
- I have temporarily or permanently lost the use of one or both legs.
- I am severely and permanently restricted in mobility due to a pulmonary or cardiovascular disability, arthritic condition, or orthopedic or neurological impairment.
- I am blind or visually impaired.
- I represent a corporation, limited liability company, partnership, or unincorporated association that provides transportation for individuals with disabilities or operates programs or facilities for such individuals.

I swear or affirm under the penalty of perjury that the information in this application is correct. It is a Class C misdemeanor to knowingly make false representations to obtain a disability plate.

Signature	Printed Name	Date Signed (mm/dd/yyyy)
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APPLICATION FOR DISABILITY PLATE OR PARKING PLACARD (continued)

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SECTION 3A - PRACTITIONER'S CERTIFICATION OF SEVERELY LIMITED MOBILITY

I certify that the applicant is severely restricted in mobility by a pulmonary or cardiovascular disability, an arthritic condition, or an orthopedic or a neurological impairment. This severe restriction in mobility is (check one):

- Permanent Temporary and is expected to end on: / / (mm/dd/yyyy)

I am (check one):

- A physician with an unlimited license to practice medicine in Indiana.
- A physician with an unlimited license to practice medicine from a state other than Indiana. *(Placards only)*
- A physician who is a commissioned medical officer of the United States Armed Forces or the United States Public Health Service. *(Placards only)*
- An advanced practice nurse licensed under Indiana Code 25-23. *(Placards only)*
- A chiropractor licensed under Indiana Code 25-10-1. *(Placards only)*
- A podiatrist licensed under Indiana Code 25-29-1. *(Placards only)*
- A physician who is a medical officer of the United States Department of Veterans Affairs. *(Placards only)*

Signature	Printed Name	Date Signed (mm/dd/yyyy)	
Telephone Number	License Number		
Address (number and street)	City	State	ZIP Code

SECTION 3B - PRACTITIONER'S CERTIFICATION OF BLINDNESS OR VISUAL IMPAIRMENT

I certify that the applicant is blind or visually impaired as defined by Indiana statute. This condition is (check one):

- Permanent Temporary and is expected to end on: / / (mm/dd/yyyy)

I am (check one):

- An ophthalmologist licensed to practice in Indiana
- An optometrist licensed to practice in Indiana

Signature	Printed Name	Date Signed (mm/dd/yyyy)	
Telephone Number	License Number		