VERMONT

Department of Motor Vehicles
Agency of Transportation

Temporary Disabled Parking Placard

802.828.2000
dmv.vermont.gov

Applicant Complete This Section

Name: **Last**	**First**	**Middle**

Mailing Address (Address Where You Get Your Mail): *If PO or Private Box, also fill in "Physical Address" below.*	City:	State:	Zip:
Physical Address (Address Where You Live) *NO PO or Private Box. .*	City:	State:	Zip:

Vermont License or Permit #	Date of Birth (mm/dd/yyyy):	Place of Birth (City, State & Country):

Social Security Number	Gender:	Eye Color:	Height:	Weight:

I make this application under provisions of 23 VSA § 304(f) and I am aware of the limitations of the use of this parking placard by other than disabled persons. I hereby affirm, under penalty of perjury, that the information on this form is true to the best of my knowledge. This declaration made under penalties of 23 VSA § 202 & § 4110.

Signature of Applicant	Date

Phone Number:	Email Address:

Licensed Physician, Certified Physician's Assistant or Licensed Advanced Practice Registered Nurse Complete This Section

☐ I certify the person named above is temporarily disabled with an ambulatory handicap

☐ I recommend that this temporary placard be valid until (Month/Year) : _____ / _____ (**NOTE:** 6 months maximum – may not be renewed)

Physician, Physician Assistant or LAPRN Name (Print)	License Number
Physician, Physician Assistant or LAPRN Name (Signature)	Date Signed

D O N O T W R I T E B E L O W - D M V U S E O N L Y

☐ 225	☐ 232	**PID:**	
☐ 227	☐ 233	**Placard #:**	
☐ 231		**Expires:**	
		Rater #:	