MAINE BUREAU OF MOTOR VEHICLES
APPLICATION FOR DISABILITY PLATES/PLACARD

☐ BMV Entered

BMV Use Only

Placard#_____

_____

_____

_____

_____

_____

Plate #_____

Issue Date: _____

Exp. Date: _____

Returned#: _____

Replaced#: _____

Issued by: _____

☐ New Application ☐ Re-Application ☐ Replacement ☐ Additional Plates/Placards

☐ **Disability Placard(s)** **Number of Placards Requested _____**

☐ **Disability Plates**

(Please provide a copy of your current registration only if you are applying for disability plates.)

Applicant's
Name: _____

Address: _____

_____ ZIP _____

Date of Birth:_____ Daytime Phone Number: (_____)_____

Contact Name:_____
(If different from applicant)

☐ Please make the expiration coincide with my license/ID's expiration _____
License/ID # (7 digits)

APPLICANT'S STATEMENT OF UNDERSTANDING

I understand that I may park in a disability parking space when the vehicle is occupied by the disabled person and the vehicle is properly displaying disability plates or a placard. I understand disability applications are valid for up to four (4) years and that I must reapply before the expiration date.

I may take this completed application to my nearest Motor Vehicle Branch Office, fax to (207) 624-9204, or mail it to:
Disability Clerk, Bureau of Motor Vehicles, 29 State House Station, Augusta, ME 04333-0029.

If you have any questions, please call (207) 624-9000 ext 52149

***** ***Altered forms will be returned to the applicant*****

Applicant's Signature _____ Date: _____

MEDICAL PROVIDER'S STATEMENT

☐ Permanent (4 year maximum) ☐ Temporary for a period of _____ months (6 months maximum)

Please check one of the following conditions:

☐ Cannot walk two hundred feet without stopping to rest.
☐ Cannot walk without the use of, or assistance from another person or the use of a brace, cane, crutch, prosthetic device, wheelchair, or other assistive device.
☐ Is restricted by lung disease to such an extent that the person's forced expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty m/hg on room air at rest.
☐ Uses portable oxygen.
☐ 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.
☐ Is severely limited in their ability to walk due to an arthritic, neurological, or orthopedic condition.

Is recovering from childbirth: **TEMPORARY PLACARD ONLY** - *check appropriate box below*

☐ Cesarean delivery – valid for 1 week following receipt of application;
☐ For the birth of a preterm infant, valid for _____ (specify length of time, not to exceed 6 months)

Medical Provider's Information:

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner ☐ Registered Nurse

(Print Name)_____ Date: _____Phone #: _____

Signature: _____License #: _____

Address: _____
City ST ZIP

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