

VETERAN CERTIFICATION OF DISABILITY

Purpose: Veterans use this form to certify to a qualifying disability and to apply for registration fee exemption and special license plates.

Instructions: Send the completed form for validation to Veterans Services Officer, 210 Franklin Road, S.W. Roanoke, VA. 24011. Submit validated form and your registration application to DMV at the address above.

VETERAN APPLICANT INFORMATION

DISABLED VETERAN NAME	DMV CUSTOMER NUMBER	DEPARTMENT OF VETERANS AFFAIRS CLAIM NUMBER
<p>CHECK THE APPROPRIATE BOX(ES) IF YOU ARE APPLYING FOR A SALES AND USE TAX EXEMPTION, LICENSE PLATE, AND/OR PLACARD DISPLAYING THE INTERNATIONAL SYMBOL OF ACCESS (DISABLED SYMBOL). NOTE: MEDICAL CERTIFICATION IS REQUIRED</p> <p> <input type="checkbox"/> DISABLED PLATE <input type="checkbox"/> DISABLED PLACARD (Permanent) <input type="checkbox"/> SALES AND USE TAX EXEMPTION </p>		

VETERANS ADMINISTRATION USE ONLY

This veteran is certified disabled as follows under provision of Virginia and/or federal law.

1. Loss of sight, limb(s) or hand(s) Loss of use of limb(s) or hand(s) Permanently and totally disabled

2. Other service-connected disability One hundred percent service-connected, permanent, and total disability

VETERANS SERVICES OFFICER NAME (print)	VETERANS SERVICE OFFICER SIGNATURE
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PHYSICIAN / PHYSICIAN'S ASSISTANT / NURSE PRACTITIONER USE ONLY

This certification may be completed and signed by a Veteran Services physician or the applicant's choice of physician, physician's assistant, nurse practitioner

<input type="checkbox"/> Cannot walk 200 feet without stopping to rest.	<input type="checkbox"/> Has been diagnosed with Alzheimer's disease or another form of dementia.
<input type="checkbox"/> Uses portable oxygen	<input type="checkbox"/> Is legally blind or deaf.
<input type="checkbox"/> Cannot walk without the use of or assistance from any of the following: another person, brace, cane, crutch, prosthetic device, wheelchair, or other assistive device.	<input type="checkbox"/> Has been diagnosed with a mental or developmental amentia or delay that impairs judgment including, but not limited to, an autism spectrum disorder.
<input type="checkbox"/> Has a cardiac condition to the extent that functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.	<input type="checkbox"/> Is restricted by lung disease to such an extent that 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 millimeters of mercury on room air at rest.
<input type="checkbox"/> Is severely limited in ability to walk due to an arthritic, neurological or orthopedic condition.	
<input type="checkbox"/> Other debilitating condition that limits or impairs the ability to walk. SPECIFY CONDITION (required)	
<input type="checkbox"/> Other condition that creates a safety concern while walking because of impaired judgement or other physical, developmental or mental limitation. SPECIFY CONDITION (required)	

CHIROPRACTOR / PODIATRIST USE ONLY

This certification may be completed and signed by the applicant's choice of chiropractor or podiatrist.

<input type="checkbox"/> Cannot walk 200 feet without stopping to rest.	<input type="checkbox"/> Is severely limited in ability to walk due to an arthritic, neurological or orthopedic condition.
<input type="checkbox"/> Cannot walk without the use of or assistance from any of the following: another person, brace, cane, crutch, prosthetic device, wheelchair, or other assistive device.	
<input type="checkbox"/> Other debilitating condition that limits or impairs the ability to walk. SPECIFY CONDITION (required)	

MEDICAL PROFESSIONAL CERTIFICATION STATEMENT

I certify and affirm that the veteran applicant identified above has a PERMANENT DISABILITY which limits or impairs his/her ability to walk due to the reason indicated above. I also certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

MEDICAL PROFESSIONAL NAME (print)	MEDICAL LICENSE NUMBER	ISSUING STATE	EXPIRATION DATE (mm/dd/yyyy)
MEDICAL PROFESSIONAL SIGNATURE	DATE (mm/dd/yyyy)	OFFICE TELEPHONE NUMBER	OFFICE FAX NUMBER