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. Physical Address Will Be Printed On Your License.* | 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: ______ / ______ (MM/YYYY)

- **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 |

**DO NOT WRITE BELOW - DMV USE ONLY**

☐ 225 ☐ 232
☐ 227 ☐ 233
☐ 231

| **PID:** | |
|---|---|
| **Placard #:** | |
| **Placard Expires:** | |
| **Rater #:** | |

VL-038 10/2017 MTC