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** **Current Plate Number:** (_____)_____

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

Applicant's Name:_____ Registrant's Name: _____

Address: _____ Address: _____

_____ ZIP _____ _____ ZIP _____

Date of Birth:_____ Date of Birth: _____

Daytime Telephone Number: (_____)_____

☐ **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 understand the Secretary of State may restrict or suspend my driver's license based on the information provided by my physician, physician's assistant, or nurse practitioner or registered nurse. With this understanding, I hereby give permission for my medical provider to release my medical history to the Secretary of State, Bureau of Motor Vehicles to determine my eligibility for a driver's license.

I may take this completed application to my nearest Motor Vehicle Branch Office 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 *Fax* (207) 624-9204

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

Applicant's Signature _____ Date: _____

MEDICAL PROVIDER'S STATEMENT

☐ Permanent (4 year maximum) – Please refer to "Certificate of Examination" on the reverse side of this form.

☐ 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: a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device.

☐ Is restricted by lung disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg of 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)

Name of Physician, Physician's Assistant, Nurse Practitioner or Registered Nurse:

*(please type)*_____ Title: _____

Signature:_____ Date: _____

Address: _____ Telephone #: _____

_____ License Number: _____

CERTIFICATE OF EXAMINATION
For Permanent Conditions Only

FOR THE REPORTING PHYSICIAN:

☐ **Please check this box if the condition does not affect the patient's ability to drive a motor vehicle. If checked, it is not necessary to complete the Functional Ability Profile below.**

1. This report is requested because the issue has been raised as to the possibility that this applicant may have a mental/physical condition that could affect his/her ability to drive a motor vehicle safely. Your report will be advisory and used to assist in determining eligibility for a driver's license. If you have any questions, please call the Medical Review Coordinator's office at (207) 624-9000, ext. 52124 *Fax*: (207) 624-9319.

2. A physician acting in good faith is immune from any damages claimed as a result of the filing of a certificate of examination pursuant to 29-A, M.R.S.A., Section 1258 (6).

FUNCTIONAL ABILITY PROFILE

This form cannot be completed without reference to the Functional Ability Profiles Booklet.

DIAGNOSIS
(Please print or type)

PROFILE LEVEL
This section must be completed.
Check only one box per diagnosis.

If COPD Profile level B or C, provide O_2 SATS

	1.	**2.**	**3.**				**4.**
			A.	B.	C.	D.	
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐

Date of last examination (must be within the past year): _____

How long has the applicant been your patient? _____

☐ No Medications

Current prescribed medication(s) and side effects experienced at present: _____

_____

_____

_____

Reliability in taking medications: _____

Date of last seizure or loss of consciousness: _____

PHYSICIAN'S COMMENTS (Important – please describe physical and/or cognitive deficits.)

_____

_____

_____

_____