

LICENSED PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER MEDICAL CERTIFICATION

(This section does not have to be completed to renew permanent placards.)

- ☐ Permanently limited or impaired. A permanent disability as it relates to disabled parking privileges shall mean: a condition that limits or impairs movement from one place to another or the ability to walk as defined in V.I. Code Title 3, Ch 14. Section 233, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.
- ☐ Temporarily limited or impaired beginning in the month of _____ and ending in the month of _____ (not to exceed 12 months).

I certify and affirm that the described applicant is my patient, whose ability to walk, based on my examination, is limited or impaired or creates a safety concern while walking.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to BMV 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		OFFICE TELEPHONE NUMBER	OFFICE FAX NUMBER
LICENSE TYPE	LICENSE NUMBER (required)	STATE ISSUING LICENSE (required)	LICENSE EXPIRATION DATE (mm/dd/yyyy) (required)
MEDICAL PROFESSIONAL SIGNATURE			DATE (mm/dd/yyyy)

LICENSED CHIROPRACTOR OR PODIATRIST MEDICAL CERTIFICATION

(This section does not have to be completed to renew permanent placards.)

- ☐ Permanently limited or impaired. A permanent disability as it relates to disabled parking privileges shall mean: a condition that limits or impairs movement from one place to another or the ability to walk as defined in V.I. Code Title 3, Ch 14. Section 233, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.
- ☐ Temporarily limited or impaired beginning in the month of _____ and ending in the month of _____ (not to exceed 6 months).

I certify and affirm that the described applicant is my patient, whose ability to walk, based on my examination, is limited or impaired or creates a safety concern while walking.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to BMV 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.

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BMV USE ONLY

PLATE/PLACARD NUMBER	PLACARD EXPIRATION DATE (mm/dd/yyyy)	EMPLOYEE SIGNATURE
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