TERRITORY OF THE U.S. VIRGIN ISLANDS
APPLICATION FOR DISABLED PERSON PARKING PERMIT PLACARD
****SUBMIT APPLICATION TO THE BUREAU OF MOTOR VEHICLES****

Purpose: Use this form to apply for a disabled parking placard.

I certify that I am a disabled person as required by Title 23, Section 96 of the Policy Regulations, VI Code, with certification from a Virgin Islands or out-of-state Physician, Osteopathic or Podiatric Physician, Optometrist (vision only) or Chiropractor.

DISABLED PARKING PLACARD ONLY
(Disabled parking placard hangs from the rearview mirror.)

CHECK ONE	PERMANENT REPLACEMENT (5 years)	TEMPORARY (1 to 6 months)	TEMPORARY REPLACEMENT
PERMANENT (5 years) ☐ Original (medical professional certification required) ☐ Renewal (No medical professional certification)	☐ Lost ☐ Stolen ☐ Destroyed ☐ Mutilated ☐ Reissue	☐ Original	☐ Lost ☐ Stolen ☐ Mutilated ☐ Reissue ☐ Destroyed

DISABLED PARKING LICENSE PLATES ONLY

ORIGINAL PLATES	DUPLICATE	REISSUE
☐ Complete and submit form VSA 10	☐ Lost ☐ Destroyed	☐ Unreadable (License plate letters or numbers unclear) ☐ Never received license plates

VEHICLE IDENTIFICATION NUMBER (VIN)	TITLE NUMBER

I am the vehicle owner and the parent/legal guardian of a disabled dependent(s). List the name of each disabled person below.

APPLICANT INFORMATION

FULL LEGAL NAME (last) (first) (middle) (suffix)	V.I. Identification Card Number

CURRENT RESIDENCE ADDRESS	CITY	STATE	ZIP CODE

CITY OR COUNTY OF RESIDENCE	DAYTIME TELEPHONE NUMBER OR CELL PHONE NUMBER

MAILING ADDRESS (if different from above)	CITY	STATE	ZIP CODE

BIRTH DATE (mm/dd/yyyy)	GENDER	HAIR COLOR	EYE COLOR	HEIGHT FT IN	WEIGHT LBS
	☐ MALE ☐ FEMALE				

APPLICANT CERTIFICATION

I understand that misuse, counterfeiting, or alteration of disabled placards may result in fines up to $1000. and up to 6 months in jail and/or revocation of disabled parking privileges. I certify that I have a (check one): Temporary Permanent disability that limits or impairs my ability to walk or creates a safety concern while walking.

I also understand that the disabled parking placard or plates issued to me cannot be loaned to anyone, including family members or friends, to benefit a person other than myself. ***Initial*** _____

I further certify and affirm that all information 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.

APPLICANT SIGNATURE	DATE (mm/dd/yyyy)

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.

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)**

BMV USE ONLY

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