Reset Form

APPLICATION FOR DISABILITY LICENSE PLATE OR PARKING PLACARD

State Form 42070 (R17 / 7-17)
Approved by State Board of Accounts, 2017
INDIANA BUREAU OF MOTOR VEHICLES

Bureau of Motor Vehicles
Winchester Mail Processing Center PO Box 100
Winchester, IN 47394
(888) 692-6841

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8. Disclosure is voluntary and you will not be penalized for refusal.

INSTRUCTIONS:
1. *Complete in blue or black ink, or print form.*
2. *To apply for a new disability license plate, complete Sections 1 and 2. If applying by mail, include payment of $9.50 (IC 9-18.1-11-10) in the form of a check or money order made payable to the BMV.*
3. *To apply for a disability parking placard, complete Sections 1 and 3. The fee for a temporary parking placard is $5.00 (IC 9-18.5-8-7(c)). If applying by mail, include payment of $5.00 in the form of a check or money order made payable to the BMV. There is no fee for a permanent parking placard or a parking placard issued to a company.*
4. *A health care provider must complete Section 4 except when the applicant is a company, or when the applicant is requesting a replacement parking placard.*
5. *Parents may sign this form on behalf of a minor child without any documentation. Any other person signing on behalf of the applicant must provide a copy of the document that authorizes that person to sign on behalf of the applicant (i.e. POA or guardianship papers). You must indicate your position next to your signature (i.e. parent or POA).*
6. *Applications may be mailed to the Winchester Mail Processing Center at the address listed above.*

SECTION 1 - APPLICANT INFORMATION

Name of Applicant *(first, middle, last) (If corporation or agency, list name.)*	Social Security Number* or Federal Identification Number	Date of Birth *(mm/dd/yyyy)*	
Address *(number and street)*	City	State	ZIP Code

SECTION 2A - APPLICATION FOR DISABILITY LICENSE PLATE

I am eligible to receive a disability license plate because: *(check one)*

- ☐ The Indiana Bureau of Motor Vehicles has issued me a permanent parking placard.
- ☐ I am certified by a health care provider in Section 4 of this application as having a permanent disability.
- ☐ I represent a corporation, limited liability company, partnership, unincorporated association, or any legal successor of a corporation, limited liability company, partnership, or unincorporated association, that is authorized by the state or a political subdivision to operate programs, including the provision of transportation, or facilities for individuals with disabilities. *(In the comments section below, a statement must be provided of how the company qualifies for the disability license plate.)*

Comments:

I swear or affirm under the penalties for perjury that the information in this application is true and correct. I understand it is a Class C misdemeanor to knowingly and falsely profess to have the qualifications to obtain a license plate for a person with a disability.

Signature of Applicant *(or company representative)*	Printed Name	Date Signed *(mm/dd/yyyy)*

SECTION 2B - VEHICLE OWNER NOT DISABLED APPLICANT

If the applicant is not the vehicle owner, the vehicle owner must complete this section. The disabled applicant must complete Sections 1 and 2A and obtain a health care provider's certification in Section 4, if required.

Name of Vehicle Owner *(first, middle, last) (if corporation or agency, list name)*	Security Social Number* or Federal Identification Number	Date of Birth *(mm/dd/yyyy)*	
Address *(number and street)*	City	State	ZIP Code

I swear or affirm under the penalties for perjury that my vehicle regularly transports the disabled applicant.

Signature of Vehicle Owner *(or company representative)*	Printed Name	Date Signed *(mm/dd/yyyy)*

SECTION 3 - APPLICATION FOR A DISABILITY PARKING PLACARD

I am applying for the following type of disability parking placard: *(check one)*

- ☐ **Permanent** *(expires only upon the health care provider's certification that the person's disability is no longer permanent)*
- ☐ **Temporary** *(expires on the date indicated by the health care provider or one (1) year after the date of issuance, whichever occurs first)*
- ☐ **Company** *(expires on January 1 of the fourth year after the year in which the placard is issued or the date on which the company ceases operations, whichever occurs first)*

I am eligible to receive a disability parking placard because: *(check one)*

- ☐ I am certified by a health care provider in Section 4 of this application as having a permanent or temporary disability.
- ☐ I am applying for a duplicate placard because the permanent or temporary placard previously issued to me has been lost, stolen, damaged, or destroyed.
- ☐ I represent a corporation, limited liability company, partnership, unincorporated association, or any legal successor of a corporation, limited liability company, partnership, or unincorporated association, that is authorized by the state or a political subdivision to operate programs, including the provision of transportation, or facilities for individuals with disabilities. *(In the comments section below, a statement must be provided of how the company qualifies for the disability parking placard.)*

Comments:

I swear or affirm under the penalties for perjury that the information in this application is true and correct. I understand it is a Class C misdemeanor to knowingly and falsely profess to have the qualifications to obtain a disability parking placard.

Signature of Applicant *(or company representative)*	Printed Name	Date Signed *(mm/dd/yyyy)*

SECTION 4 - HEALTH CARE PROVIDER'S CERTIFICATION

Name of Disabled Applicant *(first, middle, last)*	Date of Birth *(mm/dd/yyyy)*

I certify that the applicant has a qualifying disability as described in IC 9-18.5-8 and that such disability is: *(check one)*

☐ Permanent ☐ Temporary and is expected to end on : / / *(mm/dd/yyyy)*

I further certify that the applicant has/is: *(check one)*

- ☐ A physical disability that requires the use of a wheelchair, a walker, braces, or crutches.
- ☐ Lost the use of one (1) or both legs.
- ☐ A severe restriction in mobility due to a pulmonary or cardiovascular disability, an arthritic condition, or an orthopedic or neurological impairment.
- ☐ Blind (as defined in IC 12-7-2-21(2)) or visually impaired (as defined in IC 12-7-2-198).

I certify that I am: *(check one)*

- ☐ A physician with a valid and unrestricted license to practice medicine.
- ☐ A physician who is a commissioned medical officer of the armed forces of the United States or the United States Public Health Service.
- ☐ A physician who is a medical officer of the United States Department of Veterans Affairs.
- ☐ A chiropractor with a valid and unrestricted license under Indiana Code 25-10-1.
- ☐ A podiatrist with a valid and unrestricted license under Indiana Code 25-29-1.
- ☐ An advanced practice nurse with a valid and unrestricted license under Indiana Code 25-23.
- ☐ A physician assistant with a valid and unrestricted license under Indiana Code 25-27.5.
- ☐ An optometrist or ophthalmologist with a valid and unrestricted license to practice optometry or ophthalmology in Indiana.

Signature of Health Care Provider	Printed Name	Date Signed *(mm/dd/yyyy)*	
Telephone Number ( )	License Number		
Address *(number and street)*	City	State	ZIP Code

A health care provider may certify that a person's disability is no longer permanent by mailing a letter to the Indiana BMV explaining the person is no longer permanently disabled. Please provide as much of the person's information as possible. Mail the letter to:

Indiana Bureau of Motor Vehicles, Registrations Department, 100 N. Senate Avenue, N483, Indianapolis, IN 46204