



OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

**APPLICATION FOR REMOVABLE WINDSHIELD PLACARD FOR
ACTIVE DUTY MILITARY / VETERANS WITH DISABILITIES**

INSTRUCTIONS:

Note: Placard must be hung on the rear view mirror when the vehicle is parked. Remove placard when driving.

A veteran must submit the following items to qualify for gratis veteran disability placard:

1. A letter, dated within one (1) year, from the Department of Veteran's Affairs indicating that the applicant's disability is service-related, as defined in Ohio Revised Code (R.C.) 4503.44.
2. Sections A and B of this form completed (page 2)
3. Either a prescription written by the applicant's health care provider or section C of the form completed by health care provider.

If you need to contact the Department of Veteran's Affairs, the toll free number is (800) 827-1000.

An active duty military member must submit the following to qualify for a gratis disability placard:

1. Sections A and B of this form completed (page 2)
2. Either a prescription written by the applicant's health care provider or section C of the form completed by health care provider.
3. Current Department of Defense convalescent leave statement or other documentary evidence supporting that the person currently has an ill or injured casualty status or has limited duties.

PAYMENT: NO FEE FOR VETERANS OR ACTIVE DUTY MILITARY MEMBERS.

RETURN PROMPLTY: Applicants may take completed application to any local Deputy Registrar Agency or mail to the Ohio Bureau of Motor Vehicles / Registration Support Services, P.O. Box 16521, Columbus, Ohio 43216-6521. For additional information, call: **Registration Support Services (614) 752-7518** or go to www.bmv.ohio.gov.

Note: Please allow 10-15 business days for processing if mailed.

FINES AND PENALTIES

In accordance with R.C. 4511.69, no person shall stop, stand, or park a motor vehicle at special clearly marked parking locations provided in or on privately owned parking lots, parking garages, or parking areas designated for persons with disabilities without the vehicle being operated by or transporting such person and displaying a disability placard or special license plates. Whoever violates this section is guilty of a misdemeanor. The fine is at least \$250.00, but not more than \$500.00, is not punishable with imprisonment, and is not a criminal offense.

In accordance with R.C. 4731.481 and R.C. 4734.161, no health care provider shall furnish a prescription to a person to enable the person to obtain a disability placard or special license plates if they do not meet the criteria in R.C. 4503.44. Nor shall any health care provider provide the person with a prescription misrepresenting the expected length of disability. These offenses are misdemeanors of the first degree and are punishable by imprisonment of not more than six (6) months, a fine of not more than \$1,000, or both, and sanctions by the State Medical Board, the Chiropractic Examining Board or the Board of Nursing respectively.

In accordance with R.C. 4503.44, no person or organization shall misrepresent themselves as eligible for a disability placard or special license plates if they are not eligible according to the guidelines of this section. The penalty for this offense is confiscation of the placard or license plates and the revocation of privileges to obtain a disability placard or special license plates.

SECTION A

PLEASE PRINT OR TYPE

TO BE COMPLETED BY APPLICANT

NAME OF DISABLED PERSON		DL / ID / SSN OF DISABLED PERSON	
STREET ADDRESS		CITY	
STATE	ZIP CODE	COUNTY	TELEPHONE NUMBER
SIGNATURE OF DISABLED PERSON OR NEXT OF KIN OR CARE PROVIDER X			DATE SIGNED

SECTION B**INDICATE TYPE OF PLACARD REQUESTED.**

- New Placard
- Replacement
Replacement reason Damaged Lost Stolen
- Additional Placard, Please list the reason _____
- Renewal (Do not apply more than 90 days prior to expiration date.)

Previous Placard Number _____ (Applies only to renewal or replacement.)

R.C. 4503.44 allows an applicant to obtain one (1) disability placard. One (1) additional placard may be issued at the discretion of the Registrar. Therefore the applicant must state separately the reason why the additional placard is necessary.

You may make a non-refundable donation to **Opportunities for Ohioans with Disabilities (OOD)** by checking the box below and entering the amount you wish to donate. Add this to your total fees due. For more information you may contact **OOD's Division of Fiscal Management at 1-800-282-4536**.

I would like to donate \$ _____ to the Opportunities for Ohioans with Disabilities Agency.

CERTIFICATION FOR PRESCRIPTION (R.C. 4503.44)

1. Cannot walk two hundred feet without stopping to rest.	4. Uses portable oxygen.
2. Cannot walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistive device.	5. 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 standards set by the American Heart Association.
3. Is restricted by lung disease to such an extent that the person's forced (respiratory) expiratory volume for one (1) second, when measured by spirometry, is less than one (1) liter, or the arterial oxygen tension is less than sixty millimeters of mercury on room air at rest.	6. Is severely limited in the ability to walk due to an arthritic, neurological, or orthopedic condition.
	7. Is blind, legally blind, or severely visually impaired.

THE PRESCRIPTION MUST STATE THE FOLLOWING INFORMATION

Original prescriptions required (copies are not accepted)

1. Name of the person with the disability.	4. How long the disability is expected to last. The health care provider must specify an ending date, not to exceed five years, or the prescription will be rejected. Placards expire on the date specified by the health care provider.
2. Indicate you are applying for a disability placard or similar wording.	
3. The health care provider must sign and date the prescription. Pursuant to R.C. 4503.44(A)(3), health care provider means "a physician, physician assistant, advanced practice nurse, optometrist, or chiropractor as defined in this section."	

SECTION C

NAME OF HEALTH CARE PROVIDER	LICENSE NUMBER		
ADDRESS	CITY	STATE OH	ZIP CODE
EXPECTED DURATION OF DISABILITY OR PLACARD END DATE	DAYTIME PHONE NUMBER		

I certify that the named applicant has a disability that limits or impairs the ability to walk as defined above by R.C. section 4503.44.

SIGNATURE OF HEALTH CARE PROVIDER X	DATE SIGNED
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Warning: Knowingly making a false statement on this form constitutes falsification, a first degree misdemeanor punishable by criminal fines and imprisonment, and also may result in civil liability (R.C. 2921.13).