# South Carolina Department of Motor Vehicles
# Application for Placard and/or License Plate for People Who Have a Disability

RG-007A
(05/2022)

Applications are accepted at SCDMV branches or can be mailed along with a check or money order (no cash accepted) payable to **SCDMV, PO Box 1498, Blythewood, SC 29016-0019**

**Section 1 – Check type of transaction**

☐ **Original** ☐ **Renewal** ☐ **Replacement** – Prior Plate/Placard Number: _____

☐ **Add Parking Authorized** ($1.00) ☐ **Remove Authorized Person,** name:

**LICENSE PLATE** ☐ Passenger Vehicle ($36.00) ☐ Motorcycle ($10.00)

If qualified, please mark the military plate desired.

*Note: New military plates applications are processed by mail-in only.*

☐ Disabled Female Veteran Wheelchair (Must also meet requirements for Veteran who has a disability. No fee)
☐ Disabled Veteran Wheelchair (Must also meet requirements for Veteran who has a disability. No fee)
☐ Female Veteran Wheelchair *(Must also meet requirements for Veteran)*
☐ Purple Heart Wheelchair (Must also meet requirements for Purple Heart. No fee)
☐ Veteran Wheelchair *(Must also meet requirements for Veteran)*

**PLACARD – $1.00** Limit 1 per applicant. *Applicant must have a SCDL, BP, or ID photo on file with the SCDMV.* **Placard will be mailed to applicant.**

☐ Temporary (impairment must be at least 4 months, but not to exceed 1 year)
☐ Permanent (valid for 4 years)

*Placard Registration Certificate must remain in the vehicle when the placard is being used.*

**Section 2 – Person's Information** *(* indicates optional information)*

Last Name: _____ First Name: _____ Middle Name: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (*if different*): _____

*All correspondence will be mailed to the address of the applicant.*

City: _____ State: _____ Zip Code: _____

**Update Voter Registration** Unless you indicate otherwise, the addresses above will be used by the State Election Commission to update your voter registration.
☐ Do not update my residence address. ☐ Do not update my mailing address.

(Area Code) Telephone Number:* _____ Person's SC Driver License, BP, or ID Number: _____

Date of Birth:* _____ Social Security Number :* _____ Email Address:* _____

I certify that this information is true and correct.

Signature of Person _____ Printed Name of Person _____ Date _____

**Section 3 – Vehicle Information –** *(This section is **NOT REQUIRED** when only applying for a placard.)* Gross Vehicle Weight: _____

Vehicle Identification Number: _____ Make: _____ Year: _____ Current Vehicle Plate Number: _____

Owners Information

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip Code: _____ Email:* _____

(Area Code) Phone Number:* _____ SC Driver's License, BP or ID _____

☐ YES, I wish to donate $5.00, more or less, to Donate Life SC. Amount of donation $_____ .00

**INSURANCE CERTIFICATION**

Under penalties of perjury, I declare this vehicle is insured with _____ and I will maintain liability insurance throughout the registration period.
(Insurance Company)

Signature of Vehicle Owner _____ Printed Name of Vehicle Owner _____ Date _____

**Section 4 – Physician's Statement**

**A licensed Physician, an Advanced Practice Registered Nurse (APRN), or a Physician Assistant (PA) must complete this portion of the application and must indicate the disability and length of disability.** APRNs are nurse practitioners, certified nurse-midwives, clinical nurse specialists, and certified registered nurse anesthetists.

This is to certify that _____ (Name of Applicant (Please Print)) _____ (Date of Birth) has the following condition(s):

☐ An inability to ordinarily walk one hundred feet nonstop without aggravating an existing medical condition, including the increase of pain;
☐ An inability to ordinarily walk without the use of, or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device;
☐ A restriction by lung disease to the extent that the person's forced 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 on room air at rest;
☐ Requires use of portable oxygen;
☐ 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 established by the American Heart Association. If the person's status improves to a higher level, for example as a result of bypass surgery or transplantation, he or she no longer meets this criteria;
☐ A substantial limitation in the ability to walk due to an arthritic, neurological, or orthopedic condition, for example, coordination problems and muscle spasticity due to conditions that include Parkinson's disease, cerebral palsy, or multiple sclerosis; or
☐ Blindness.

This disability is: ☐ Permanent ☐ Temporary – length of time _____ ***(Impairment must be at least for 4 months, but not to exceed 1 year)***

I certify that I am: ☐ a licensed Physician ☐ an APRN ☐ a PA Professional License No. _____ Physician Office Phone No.: _____

Printed Name of Physician, APRN, or PA _____ Signature of Physician, APRN, or PA _____ Date _____

| **DMV USE ONLY** | Check No. | Amount | Plate No. | Placard No. | TLS Initials |
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