John J. Barthelmes
Commissioner of Safety

State of New Hampshire
DEPARTMENT OF SAFETY
DIVISION OF MOTOR VEHICLES

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Director of Motor Vehicles

APPLICATION FOR WALKING DISABILITY PRIVILEGES

(Please see reverse side for Frequently Asked Questions)

Section I – Applicant's Information

This section must be completed and signed by the applicant (the person with the walking disability). If signed by a third party, please attach all approved documentation (guardianship, power of attorney, etc.)

Name: _____ **Date of Birth:** _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip Code

_____ _____ _____
Driver License or Non-Driver ID # (please write "none" if you do not have one) *Telephone Number* *E-Mail Address (Optional)*

Upon approval of this application you will be issued one of the following. Please make your selection below:

☐ One (1) placard

☐ Two (2) placards (If you already have or are applying for Walking Disability plates you are not eligible for 2 placards)

☐ Walking Disability plates (for first time) & one (1) placard **Fee $8.00 (Permanent walking disability privileges required. Please send a copy of your current registration). For renewals, please see reverse side of this form.**

I, the undersigned applicant, certify under penalty of unsworn falsification pursuant to RSA 641:3, that I am a resident of this State qualified for walking disability privileges pursuant to RSA 261:88.

Signature of Applicant: _____ **Date:** _____

Section II – Medical Provider Information (This section must be completed by your medical provider)

Please **CHECK ONE** of the following:

☐ Please issue a placard for a **TEMPORARY** disability for a period of _____ months (**cannot exceed 6 months**)

☐ Please issue a placard for a **PERMANENT** disability (These placards require periodic renewal/recertification per RSA 261:88.)

Please **CHECK ONE** of the following:

I am a: ☐ Licensed Physician ☐ Podiatrist ☐ Advanced Practice Registered Nurse (APRN) ☐ Physician Assistant

Please **CERTIFY** as follows: I certify, under penalty of unsworn falsification pursuant to RSA 641:3, that the person whose name appears above is under my treatment/care and, in my professional opinion, has a walking disability as defined/used under RSA 259:124 and RSA 261:88. RSA 261:88 includes the following criteria:

I. Cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device; or

II. Is restricted by lung disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than 1 liter, or the arterial oxygen tension is less than 60 mm/hg on room air at rest; or

III. Uses portable oxygen; or

IV. Has a cardiac condition to the extent that the person's functional limitations are classified in severity as class 3 or class 4 according to standards set by the American Heart Association; or

V. Is severely limited in the ability to walk due to an arthritic, neurological, orthopedic, or other medically debilitating condition.

Please print legibly. Original Signature of Medical Provider is required. Signed under penalty of unsworn falsification (see above).

Name of Medical Provider: _____ **Telephone:** _____

Medical Provider Address: _____

Medical Provider Signature: _____ **Date:** _____