NEW HAMPSHIRE APPLICATION FOR WALKING DISABILITY PRIVILEGES

Incomplete applications cannot be processed.
Both disabled person and medical professional signatures are required.

1. Disabled Person's Information: (Please Print)

NAME: _____ _____
FIRST **MIDDLE** **LAST** **DATE OF BIRTH**

MAILING ADDRESS: _____
STREET **CITY/TOWN** **STATE** **ZIP CODE**

_____ _____ _____
DRIVER LICENSE NUMBER / NON DRIVER IDENTIFICATION NUMBER **BEST CONTACT PHONE NUMBER (RECOMMENDED)** **EMAIL ADDRESS**

I am applying for one of the following:

☐ One placard (no charge).
☐ Additional placard (no charge, maximum of 2 placards per resident).
☐ Walking Disability Plate ($8 fee for initial issuance, no fee for renewals. Permanent Disability only, must complete section 3).
☐ Walking Disability Vanity Plate (Permanent Disability only, must complete section 3 below and an Application for Initial Plates (RDMV120).

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.

Applicant/Power of Attorney Signature: _____ **Date:**_____
NOTE: Power of Attorney must supply appropriate documentation, including a copy of the Power of Attorney.

2. Medical Provider Information: Please check only one:

☐ **Permanent** ☐ **Temporary: for a period of _____ Months** (cannot exceed six (6) months)

I certify the above applicant meets one of the criteria listed below:

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 60mm/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 the 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 disabling condition.

I certify, under penalty of unsworn falsification, that the person whose name appears is under my treatment and care and in my professional opinion has a walking disability as defined under RSA 259:124.

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

Physician's Address: _____

Print Name: _____ Contact Phone Number: _____

Signature: _____ **Date:** _____

3. Walking Disability Plate Information: Submit a copy of the current registration of the vehicle you wish to obtain plates for and a completed Application for Initial Plates (RDMV 120):

☐ This is my own vehicle.
☐ This vehicle is registered to a relative residing in my household and provides primary transportation for me.
Household Member Information:
Print Name:_____ DOB:_____ Relation to Applicant: _____

I certify under penalty of unsworn falsification pursuant to RSA 641:3, that I provide primary transportation for the named applicant, as a member of that relative's household.

Vehicle Owner's Signature: _____ **Date:**_____
NOTE: Power of Attorney must supply appropriate documentation, including a copy of the Power of Attorney.

Please submit all documentation to NH DMV Attn: Walking Disability, 23 Hazen Drive, Concord, NH 03305-0001
Please make Checks payable to: **State of NH-DMV**
Phone: (603) 227-4000
www.nh.gov/dmv