



**STATE OF TENNESSEE  
DEPARTMENT OF SAFETY  
TITLE AND REGISTRATION DIVISION  
44 VANTAGE WAY, SUITE 160  
NASHVILLE, TENNESSEE 37243-8050**

**APPLICATION FOR DISABLED PERSON LICENSE PLATE AND /OR PLACARD**

**Application must be completed in the name of the applicant. Please complete all information and sign.**

Please check the item requested: <input type="checkbox"/> Permanent Placard \$21.50 <input type="checkbox"/> Temporary Placard \$10.00 <input type="checkbox"/> Renewal Temporary Placard \$10.00 <input type="checkbox"/> Renewal Permanent Placard \$3.00 <input type="checkbox"/> Replacement Placard \$2.00 <input type="checkbox"/> *Disabled/Person License Plate	FIRST NAME	MIDDLE NAME	LAST NAME	
	STREET ADDRESS			
	CITY OR TOWN	COUNTY	STATE	ZIP CODE
	DATE OF BIRTH	MONTH	DAY	YEAR

(\*The county clerk will collect the necessary fees for the assignment of the disabled person license plate. Exchange plate must be surrendered to county clerk before credit can be given.)

Tennessee Codes Annotated (T.C.A.) 55-21-103(f)(1) states: "Any person issued a permanent or temporary placard must submit a new certification pursuant to T.C.A. 55-21-102(1)(A) or (C), prior to the department renewing such permanent or temporary placard." (Please read reverse side.)

If application is for placard only, it is unnecessary to complete this portion of the application pertaining to identification to the vehicle.

Description of vehicle to which plates will be affixed	YEAR	MAKE OF VEHICLE	TITLE NUMBER
VEHICLE IDENTIFICATION NUMBER (VIN)			

I, the undersigned applicant, hereby certify, under the penalties prescribed in chapter 55-21-108, Tennessee Code Annotated, that the statements made herein are true and correct to the best of my knowledge, information and belief.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**The following section must be completed by a medical doctor  
licensed to practice medicine or a Christian Science practitioner listed in the Christian Science Journal**

Mechanical device used: Crutches \_\_\_\_\_ Braces \_\_\_\_\_ Other (List) \_\_\_\_\_  
 Is applicant PERMANENTLY confined to a wheelchair? Yes \_\_\_\_\_ No \_\_\_\_\_  
 The nature of the disability is \_\_\_\_\_  
 Physician's or Christian Science Practitioner's Name \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone No. \_\_\_\_\_

I hereby certify that the applicant named in this application has appeared before me and that, in my opinion, he or she meets the requirements of T.C.A. 55-21-102(1)(A), (B), and (C).

Physician's or Christian Science Practitioner's Signature \_\_\_\_\_ Date \_\_\_\_\_

**TITLE AND REGISTRATION DIVISION/COUNTY CLERK USE ONLY**

Approved By	Date Approved	Placard Number Assigned	Expiration Date
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