Delaware Division of Motor Vehicles

FORM MV549

DAV-HP License Plate Application

Date of Application: _____ Email Address: _____ DAV Assigned Plate Number: _____

Name: _____ Telephone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Registration #: _____ MFG & Year: _____ VIN #: _____

In accordance with 21 *Del.C.* §2138

1. The applicant states that:
   a. The applicant is a veteran with a disability of any war, the Korean conflict, the Vietnam conflict, Operation Desert Storm or other military conflict on foreign soil in which United States armed forces were formally engaged in battle; or
   b. It has been determined by the United States Department of Veterans Affairs that the applicant meets the qualifications of being a veteran with a service-connected disability; and
2. a. The United States Department of Defense certifies that the applicant sustained a disabling injury in any war, the Korean conflict, the Vietnam conflict, Operation Desert Storm or other military conflict on foreign soil in which United States armed forces were formally engaged in battle; or
   b. The United States Department of Veterans Affairs certifies that the applicant meets the qualifications of being a veteran with a service-connected disability.

A copy of the certification letter from the Veterans Administration Office stating the applicant has a service connected disability must be submitted with the application and will be retained by the Division of Motor Vehicles. This letter can be obtained through VA.gov.

I understand that the special disabled veteran license plate is to be displayed only on the rear of the vehicle described above. (If you trade vehicles, your registration card showing the DAV plate must be presented to the DMV so a new card can be issued.)

A one-time fee of $10 must accompany this application. Application and documentation may be presented at any DMV office.

Plate may be issued only on a private passenger vehicle or a truck with a 14,000 pound or less manufacturer's gross vehicle weight rating (MGVWR).

Plates will be mailed to the address listed on this application in approximately 6-8 weeks.

Applicant Signature: _____ Date: _____

I am applying for a special “Disabled Veteran-HP” license plate.

I hereby certify that I am a disabled veteran, having sustained a disabling injury in:

Name of War/Conflict: _____



THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR PHYSICIAN FOR FIRST TIME ISSUANCE OF LICENSE PLATE

In accordance with 21 *Del.C.* §2134 Eligibility, by law, for a long-term plate is restricted to permanent disabilities with no prognosis for improvement. **No other person is eligible for a license plate**. A physician must certify this application. Applicant must meet one of the following requirements with no prognosis for improvement:

- ☐ 1. Cannot walk 200 feet without stopping to rest.
- ☐ 2. Cannot walk safely without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistive device.
- ☐ 3. Is restricted by lung disease to such an extent that the applicant's or household member's forced (respiratory) expiratory volume, one second, when measured by spirometry, is less than one liter or the arterial oxygen tension is less than 60 mm/hg. at room air or rest.
- ☐ 4. Uses portable oxygen.
- ☐ 5. Has a cardiac condition to the extent that the applicant's or household member's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association.
- ☐ 6. Is severely limited in their ability to walk due to an arthritic, neurological or orthopedic condition.

PHYSICIAN MUST PROVIDE THEIR CERTIFICATION BELOW

I certify, under penalty of law, that the above information concerning the applicant is true and correct, and that the applicant meets the requirements specified above for the long-term special license plate.

Date: _____ Physician's Signature: _____ License #: _____

PRINT NAME, ADDRESS AND TELEPHONE NUMBER OF LICENSED PHYSICIAN and APPLICANT NAME:

Applicant's Name: _____ Physician's Name: _____

Physician's Street Address or P.O. Box: _____ City: _____ State: _____ Zip Code: _____

Physician's Office Telephone #: _____ Physician's Office Contact Name: _____

****NOTE: A PHYSICIAN'S SIGNATURE IS NOT REQUIRED TO RENEW A PLATE FOR A PERSON WITH A PERMANENT DISABILITY OR IF THE APPLICANT IS 80 AND OLDER****

In accordance with 21 *Del.C.* §2135 (j)(1) I certify, under penalty of law, that the above information is true and correct. I also understand that false representation by me can lead to penalties as provided by law as follows: Any person who is not disabled, as defined above, and who intentionally and falsely represents that such person has the qualifications to obtain such a special license plate in an attempt to obtain such plate shall for the first offense be fined $100. For each subsequent like offense, the person shall be fined $200 or imprisoned not less than 10 or more than 30 days, or both.

NOTE: I understand the special license plate must be returned when no longer needed.

Applicant Signature: _____ Date: _____

Approval of DMV Associate: _____