Non-Revenue Tag Application Permanent Upper Limb Mobility Impairment

In accordance with Section § 33.2-613. D of the Code of Virginia

Part I - To be completed by the person eligible for the Non-Revenue Tag

Name: ______________________________

Wk Phone: ______________ Home Phone: ______________

Address: ______________________________

City: ______________ State: ______________ Zip: ________

Vehicle Information for Non-Revenue Transponder

Drivers License #: ______________ State Licensed: ______________

Car License #______________ State: ______________

Make: ______________ Model: ______________

Year: ______________ Color: ______________

Vehicle ID # (VIN): ______________________________

Part II - I Certify and Acknowledge:

1. That the vehicle describe above is specially equipped to permit its operation by a person who is severely physically disabled and having permanent upper limb mobility or dexterity impairments which substantially impair his/her ability to deposit coins in toll baskets. The tag issued for use in this vehicle will only be used in this vehicle by the person to whom the tag was issued. Failure to adhere to this agreement will result in revocation of the transponder's non-revenue status and subject the user to applicable violation penalties and fees.
2. That I hold a valid driver's license issued by: ______________________________
State
3. That if the reason for my obtaining a non-revenue tag no longer exists, I am required to return my non-revenue tag to the nearest E-ZPass Customer Service Office.
4. That if my non-revenue transponder is lost, I may obtain a new one, but will be charge a fee of $10.00 for a lost standard transponder and $20 for a lost Flex transponder. If my non-revenue transponder is stolen and I have a police report, the lost/stolen fee will be waived. In both cases the original non-revenue transponder will be deactivated.

______________________________ ______________
Signature Date

Signature Must Be Notarized Below

Notary, please use state seal

Commonwealth of Virginia

City/County of______________________________ to wit:

The above signature was acknowledged before me this __________ day of __________, 20________

My commission expires: ______________

____
NOTARY PUBLIC

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Part III - To be completed by a Physician/Nurse Practitioner/Physicians Assistant ONLY

Patients Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ________

PHYSICIANS CERTIFICATION:

In accordance with Section § 33.2-613. D of the Code of Virginia, the above person is requesting free toll passage on Virginia Toll Roads. Please verify that the person above qualifies for this privilege. In accordance with Section § 33.2-613. D of the Code of Virginia the requestor must be severely physically disabled and having permanent upper limb mobility or dexterity impairments which substantially impair his/her ability to deposit coins in toll baskets.

PHYSICIAN / PA / NURSE PRACTITIONER CERTIFICATION

Must be filled out completely to be valid - All information subject to verification

Please use official stamp

Physician/Nurse Practitioner Name (Print)	Physician/Nurse Practitioner Signature	
Date	Medical License Number	
License Expiration Date (mm/dd/yyyy)	Medical Specialty	
State Issuing License to Practice	Business Address	
City	State	ZIP
Telephone Number	Fax Number	