



Field Services Division
Reno/Carson City 684-4DMV
Las Vegas 486-4DMV
Rural NV (877) 368-7828
www.dmvnv.com

MINOR APPLICATION TO TRANSPORT MEDICALLY DISABLED

Approved:\_\_\_\_\_ Denied:\_\_\_\_\_ Reason: \_\_\_\_\_

INSTRUCTIONS: Please type or print in black ink. Failure to complete all sections AND to attach a Physician's Statement will cause considerable delay in processing the application.

Name of Minor \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Male Female Height \_\_\_\_\_ Weight \_\_\_\_\_ Hair \_\_\_\_\_ Eyes \_\_\_\_\_

Name of Disabled Person \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security Number of Disabled Person \_\_\_\_\_

Both Reside at \_\_\_\_\_

Mailing Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Father/guardian (If other than disabled person)

Name: \_\_\_\_\_ Drivers License No. \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Work Days/hours \_\_\_\_\_

Mother/guardian (If other than disabled person)

Name: \_\_\_\_\_ Drivers License No. \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Work Days/hours \_\_\_\_\_

Is there any other licensed driver(s) residing in the household? Yes\_\_\_\_\_ No\_\_\_\_\_

If Yes, please complete the following:

Name \_\_\_\_\_ Drivers License No. \_\_\_\_\_

Name \_\_\_\_\_ Drivers License No. \_\_\_\_\_

Explanation of Medical Hardship and Need for Applicant to Drive

\_\_\_\_\_

WE / I HEREBY CERTIFY THAT THE MINOR AND DISABLED PERSON ARE NEVADA RESIDENTS AND BOTH RESIDE AT THE SAME ADDRESS. WE / I FURTHER CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL STATEMENTS MADE ON THIS APPLICATION ARE TRUE AND CORRECT AND UNDERSTAND THAT ANY MISSTATEMENT MAY CAUSE DENIAL AND / OR CANCELLATION OF THE LICENSE.

FATHER/GUARDIAN SIGNATURE

MOTHER/GUARDIAN SIGNATURE

APPLICATION CONTINUES ON THE REVERSE SIDE

PHYSICIAN'S STATEMENT: PLEASE ATTACH A SEPARATE STATEMENT FROM AN ATTENDING PHYSICIAN AS TO THE NATURE OF THE MEDICAL CONDITION AND THE INABILITY OF THE DISABLED PERSON TO OPERATE A MOTOR VEHICLE. THE STATEMENT MUST INDICATE WHETHER THE CONDITION IS PERMANENT OR, IF IT IS A SHORT TERM DISABILITY, THE LENGTH OF TIME ESTIMATED FOR THE DISABILITY. THE STATEMENT MUST BE AN ORIGINAL DOCUMENT ON THE PHYSICIAN'S LETTERHEAD AND DATED WITHIN THE PAST THIRTY ( 30 ) DAYS.

DATE/TIME/LOCATION OF SCHEDULED DOCTOR APPOINTMENTS OR THERAPY

( If necessary, please attach an additional sheet.)

Physician or Therapy: \_\_\_\_\_ Phone: \_\_\_\_\_

Address of Appointment: \_\_\_\_\_ City: \_\_\_\_\_

GROCERY OR DRUG STORE TRAVEL:

Name of grocery store: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Mileage one way from residence to store via most direct route \_\_\_\_\_

Route of travel: \_\_\_\_\_

Name of drug store: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Mileage one way from residence to store via most direct route \_\_\_\_\_

Route of travel: \_\_\_\_\_

You may specify two days each week and a maximum of two hours each day to grocery shop or obtain drug store items:

Days \_\_\_\_\_ Hours \_\_\_\_\_

License plate number of vehicle to be used by minor: \_\_\_\_\_

I / WE ACCEPT ALL LIABILITIES FOR ANY NEGLIGENCE OR WILLFUL MISCONDUCT ON THE PART OF THE MINOR AND AGREE THAT FAILURE OF THE MINOR TO COMPLY WITH THE FOLLOWING RESTRICTIONS AND/OR ANY CONDITIONS OF THE LICENSE MAY RESULT IN CANCELLATION OF THIS PRIVILEGE:

- License will be effective for the specified period of time;
- Licensee may not transport passengers other than the individual named in the application;
- The route, days, and hours of travel shall be confined as determined by the Field Services Division;
- The undersigned will notify the Field Services Division if the need no longer exists.

\_\_\_\_\_  
FATHER/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
MOTHER/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

SUBSCRIBED and SWORN to or affirmed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
**NOTARY PUBLIC**