



555 WRIGHT WAY  
 CARSON CITY, NV 89711  
 Reno/Sparks/Carson City (775) 684-4DMV (4368)  
 Las Vegas Area (702) 486-4DMV (4368)  
 Rural Nevada or Out of State (877) 368-7828  
[www.dmvnv.com](http://www.dmvnv.com)

**APPLICATION FOR AN EXPEDITED SERVICE PERMIT  
 NRS 426.441**

Nevada law allows for issuance of an Expedited Service Permit for individuals with a permanent (irreversible) disability. This permit entitles a person to expedited service from any officer or employee of a State agency that is providing any services of the agency to the public. The Expedited Service Permit is valid for 10 years from date of issuance.

**APPLICATION FOR AN EXPEDITED SERVICE PERMIT MUST BE MADE IN PERSON**

*Original* \_\_\_\_\_ *Duplicate/Change* \_\_\_\_\_

Applicant's Name \_\_\_\_\_  
 (Disabled Person) Last First M.I.

Date of Birth (Mandatory) \_\_\_\_\_ Daytime Telephone No. (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
 City State Zip Code

I currently have Disabled License Plate No. \_\_\_\_\_ I currently have Disabled Placard(s) No(s). \_\_\_\_\_ / \_\_\_\_\_

I understand that it is unlawful for an individual, other than myself, to use or attempt to use this Expedited Service Permit and that a person who violates this provision is guilty of a misdemeanor.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**Fees:** 65 Years of age or older – Original, duplicate or renewal: \$7.00  
 Under 18 years of age – Original, duplicate or renewal: \$6.00  
 All Others – Original, duplicate or renewal: \$12.00  
 New Photograph or change of name or both: \$7.00

**THIS PORTION MUST BE COMPLETED BY A LICENSED PHYSICIAN**

**Do not complete if you have previously provided the Nevada Department of Motor Vehicles with a physician's certificate indicating an irreversible condition.**

As a Physician for the above-named patient, I hereby certify that the applicant:

1. \_\_\_\_\_ Cannot walk two hundred feet without stopping to rest.
2. \_\_\_\_\_ Cannot walk without the use of a brace, cane, crutch, wheelchair, or other device or another person.
3. \_\_\_\_\_ Is restricted by a lung disease.
4. \_\_\_\_\_ Uses portable oxygen.
5. \_\_\_\_\_ Has a cardiac condition to the extent that functional limitations are classified as a Class III or Class IV according to standards adopted by the American Heart Association.
6. \_\_\_\_\_ Is visually handicapped.
7. \_\_\_\_\_ Is severely limited in his/her ability to walk because of an arthritic, neurological, or orthopedic condition.

**And I further certify that my patient's condition is:**

Irreversible, the patient is permanently disabled in his/her ability to walk (certification is valid indefinitely).

**Please Print or Type:**

Physician's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_  
 City State Zip Code

Physician's License Number \_\_\_\_\_ Telephone No. (\_\_\_\_\_) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_