



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



Non-Revenue Tag Application Permanent
 Upper Limb Mobility Impairment In accordance
 with Section § 33.2-613. D
 of the Code of Virginia

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	