



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
Fax (775) 684-4797
www.dmvnv.com

EXPEDITED SERVICE PERMIT APPLICATION
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 Application [] Duplicate or Change

Please Print or Type

Full Legal Name (Disabled Person) _____

First Middle Last

Nevada Driver's License or Identification Card Number _____ Date of Birth ____/____/____

Physical Address _____ Address City State Zip Code

Mailing Address _____ Address City State Zip Code

County of Residence _____ Telephone No _____ E-Mail Address _____

I currently have Disabled License Plate number _____ I currently have Disabled Placard(s) number(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 for original, duplicate, or renewal: 65 years of age or older - \$7.00
Under 18 years of age - \$6.00
All others - \$12.00
New Photograph or change of name or both - \$7.00

A LICENSED PHYSICIAN MUST COMPLETE THIS PORTION*

Do Not complete this section 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. _____ 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.
4. _____ Is restricted by a lung disease.
5. _____ Is severely limited in his/her ability to walk because of an arthritic, neurological, or orthopedic condition.
6. _____ Is visually handicapped.
7. _____ Uses portable oxygen.

I further certify that my patient's condition is:

[] Permanent Disability (irreversible, permanently disabled in his/her ability to walk, certification is valid indefinitely).

Physician's Name _____ First Middle Last

Mailing Address _____ Address City State Zip Code

Physicians License Number _____ Telephone No _____

Physician's Signature _____ Date _____