August 20, 2018

Virginia Department of Transportation

REQUEST FOR PERSON WITH DISABILITY SIGN

Purpose: Persons with a disability or their agent use this form to request "Person with Disability" Signs.

Instructions: Submit the completed form to the local VDOT office for the location where the sign is being requested. See http://www.virginiadot.org/about_vdot/residencies.asp for your local VDOT office and their contact information.

REQUESTORS INFORMATION (PERSON WITH DISABILITY)

Name: _____ _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____ **VA** _____

City *State* *ZIP Code*

Phone: _____ Email (optional): _____

Does the request pertain to a person who generally uses a wheelchair? ☐ Yes ☐ No

(This pertains to the type of signs used).

LOCATION OF SIGN REQUEST

If the requested sign is at a different address than indicated above for the person with a disability, enter that address below (otherwise leave blank).

_____

Street Address *Nearest Cross Street*

_____ **VA** _____

City *State* *ZIP Code*

Provide additional information below (or attach) regarding the nature of the request and describing the location of the requested sign such as a map or sketch indicating the section of roadway where it is anticipated the person with disability may be on or near the roadway or crossing the roadway. Also, indicate if the requested sign is at a crosswalk or signalized intersection or in a school area.

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MEDICAL CERTIFICATION

Medical Professional's Name: _____ Date: _____
Last *First* *M.I.*

Office Address: _____
Street Address *Suite/Unit #*

_____
City *State* *ZIP Code*

Office Phone: _____

I certify and affirm that I am one of the following (check all that apply)

☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

I further affirm that the person indicated below is my patient and is one or more of the following: deaf, blind, deaf-blind, autistic or has an intellectual or developmental disability as defined in § 37.2-100 of the Code of Virginia.

Per § 37.2-100 "Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

_____
Patient's Last Name *Patient's First Name* *Patient's M.I.*

Medical Professional's Signature: _____ Date: _____

CERTIFICATION OF REQUESTOR, GUARDIAN OR AGENT

I certify that the information above is true and complete to the best of my knowledge and that I will notify VDOT of any future change in circumstances such that the request is no longer valid or the signs are no longer necessary.

Name: _____ Date: _____
Last *First* *M.I.*

Signature: _____