NOTE: ONLY ORIGINAL SIGNATURES WILL BE ACCEPTED—NO FAXES OR PHOTOCOPIES. ANY ALTERATIONS, CROSSOVERS, OR WHITEOUT WILL VOID THIS FORM (INCLUDING CHANGES WITH INITIALS) AND WILL BE RETURNED TO THE PATIENT. ORIGINAL FORMS AND MOST CURRENT VERSION IS AVAILABLE AT WWW.DMV.CA.GOV, AND AT ALL DMV OFFICES.

A full legible description of the illness or disability **must be provided** for numbers 3, 4, 5, 6 and 7 below. A licensed physician, surgeon, physician assistant, nurse practitioner, or certified nurse midwife, may certify to items 1–7, a licensed chiropractor may certify to items 5–7 only, and a licensed physician or surgeon who specializes in diseases of the eye or a licensed optometrist may only certify to item 8.

My patient meets the requirements of a disabled person found in California Vehicle Code (CVC) §295.5 as he or she suffers from the following:

PRINT DISABLED PERSON'S NAME: Robert Morradian

1. ☐ A lung disease to the extent that forced (respiratory) expiratory volume for one second when measured by spirometry is less than one liter **or** arterial oxygen tension (pO2) is less than 60 mm/Hg on room air while the person is at rest.
2. ☐ A cardiovascular disease to the extent that the person's functional limitations are classified in severity as class III or class IV based upon standards accepted by the American Heart Association.
3. ☐ A diagnosed disease or disorder which substantially impairs or interferes with mobility due to *(please print)*:
4. ☐ A severe disability in which he or she is unable to move without the aid of an assistive device, which is due to *(please print)*:
5. ☒ A significant limitation in the use of lower extremities due to *(please print)*: S/p (R) tibia fracture s/p internal fixation surgery
6. ☐ The loss, or loss of the use of one or more lower extremities. Loss of use due to *(please print)*:
7. ☐ The loss, or loss of the use of, both hands. Loss of use due to *(please print)*:
8. ☐ Central visual acuity does not exceed 20/200 in the better eye, with corrective lenses, as measured by the Snellen test, or visual acuity that is greater than 20/200, but with a limitation in the field of vision such that the widest diameter of the visual field subtends an angle not greater than 20 degrees.

MUST CHECK THE APPROPRIATE BOX(ES).

☐ **PERMANENT PLACARD** (CVC §22511.55)	☒ **TEMPORARY PLACARD** Valid until: Month 8 Day 31 Year 2013 (Cannot exceed six months—Cannot be renewed more than six times consecutively [CVC §22511.59(b)].)	☐ **TRAVEL PLACARD** Valid until: Month ____ Day ____ Year ____ (Cannot exceed 30 days for a California resident and 90 days for a non-resident [CVC §22511.5(d)].)

PRINT AUTHORIZED MEDICAL PROVIDER'S NAME (LAST, FIRST, MIDDLE): Teasdale, Robert

AUTHORIZED MEDICAL PROVIDER'S DAYTIME TELEPHONE #: (415) 461-4150

AUTHORIZED MEDICAL PROVIDER'S ADDRESS: 1375 South Eliseo Dr. CITY: Greenbrae STATE: CA ZIP CODE: 94904

I certify that I am a ☐ **Physician** ☒ **Surgeon** ☐ **Chiropractor** ☐ **Optometrist** ☐ **Physician Assistant** ☐ **Nurse Practitioner** ☐ **Certified Nurse Midwife** and I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I also certify that I will retain information sufficient to substantiate this certification and shall make that information available for inspection by the Medical Board of California at the department's request. (CVC §22511.55).

EXECUTED AT (CITY, STATE): Greenbrae

DATE: 5-10-13

AUTHORIZED MEDICAL PROVIDER'S SIGNATURE (SIGN ONLY AFTER NAME OF PATIENT HAS BEEN PRINTED ABOVE IN SECTION F)

X

MEDICAL LICENSE NUMBER: 63292

When this form is completed, it may be mailed to: **DMV Placard, P.O. Box 932345, Sacramento, CA 94232-3450** or submitted to any DMV office. It is recommended that you make an appointment if submitting this form to your nearest DMV office, by calling 1-800-777-0133.

SIGNATURE OF DMV EMPLOYEE

X

LINE DATE STAMP

REG 195 (REV 4-2011)