



# Sun-Shading Medical Authorization Application

DMV USE ONLY
LOG NUMBER

**Purpose:** Use this form to apply for a sun-shading medical authorization or to add additional vehicle(s) to an existing sun-shading medical authorization.

**Instructions:** Complete this form in its entirety and return to any DMV customer service center, mail to DMV at the address above, or fax to (804) 367-1384. Once processed, you will receive a new vehicle registration card with a sun-shading notation on the left side of the card.

**NOTE:** Medical Provider Certification is required for new applications only - not subsequent applications.

APPLICATION TYPE	
CHECK ONE: <input type="checkbox"/> New Application (apply for sun-shading medical authorization)	<input type="checkbox"/> Subsequent Application (add vehicle(s) to existing sun-shading medical authorization)

SUN-SHADING ALLOWANCES INFORMATION			
To be eligible for sun-shading, as provided in Va Code §§ 46.2-1052 and 46.2-1053, the vehicle must be equipped with both left and right outside mirrors.			
Total Percentage of Light Transmittance Allowed			
Vehicle Window	Without Medical Authorization		With Medical Authorization
	Regular Passenger Vehicles	Multi-Use Passenger Vehicles	
Windshield	No sun-shading allowed	No sun-shading allowed	35% - upper 5 inches to AS-1 line 70% windshield
Front Side Windows	50%	50%	35%
Rear Side Windows	35%	No limitations	35%
Rear Window	35%	No limitations	35%

VEHICLE OWNER INFORMATION			
VEHICLE OWNER NAME (print)		DMV CUSTOMER NUMBER	
RESIDENCE/HOME ADDRESS		DAYTIME TELEPHONE NUMBER (       )	
CITY		STATE	ZIP CODE
MAILING ADDRESS (if different from above)			
CITY		STATE	ZIP CODE

VEHICLE INFORMATION					
Identify each vehicle to be equipped with sun-shading material (List additional vehicles on reverse.)					
Year	Make	Model	Title Number	Identification Number (VIN)	License Plate Number

VEHICLE OWNER CERTIFICATION	
I hereby acknowledge that Virginia Code §46.2-1053 only authorizes me to apply tint to the windows and windshield of my motor vehicle(s) up to the total levels provided in the "Sun Shading Allowances" table above. I also understand that the law does not authorize me to have darker tinting applied, even with a medical provider's recommendation. I further certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation. This waiver is valid until the vehicle is sold or transferred to another person or until the medical condition no longer exists, whichever occurs first. The sun-shading must be removed from the vehicle at that time.	
APPLICANT/LEGAL GUARDIAN'S SIGNATURE	DATE (mm/dd/yyyy)

MEDICAL PROVIDER CERTIFICATION			
CHECK BOX THAT APPLIES: <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> NURSE PRACTITIONER <input type="checkbox"/> PHYSICIAN ASSISTANT <input type="checkbox"/> OPHTHALMOLOGIST <input type="checkbox"/> OPTOMETRIST			
PATIENT NAME (print)		PATIENT BIRTHDATE (mm/dd/yyyy)	
MEDICAL PROVIDER NAME (print)		LICENSE NUMBER	
BUSINESS ADDRESS		TELEPHONE NUMBER (       )	
CITY	STATE	ZIP CODE	FAX NUMBER (       )
Based on my examination, vehicle sun-shading is necessary for my patient's health. <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, describe the medical condition that requires the use of sun-shading.			

I hereby acknowledge that Virginia Code §46.2-1053 only authorizes the application of tint to the windows and windshield of any motor vehicle up to the total levels provided in the "Sun Shading Allowances" table above. I also understand that any recommendation for darker tint will subject the vehicle and its owner to a Virginia Code violation. I further certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.	
MEDICAL PROVIDER SIGNATURE	DATE (mm/dd/yyyy)