www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

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: Print or type all information. Mail to DMV Direct at the address above or fax to (804) 497-7117.
NOTE: To ensure that DMV is able to process your application, complete this form in its entirety. Medical Provider Certification is required for new applications only - not subsequent applications.

APPLICATION TYPE

CHECK ONE: ☐ New Application (apply for sun-shading medical authorization) ☐ 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	SOCIAL SECURITY NUMBER (optional)

RESIDENCE/HOME ADDRESS	DAYTIME TELEPHONE NUMBER ( )

CITY	STATE	ZIP CODE

☐ Check if a new address. If you change your residence/home or mailing address to a non-Virginia address, your driver's license and/or photo identification (ID) card may be canceled.

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	Driver License 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.

APPLICANT/LEGAL GUARDIAN'S SIGNATURE	DATE (mm/dd/yyyy)

MEDICAL PROVIDER CERTIFICATION

CHECK BOX THAT APPLIES: ☐ PHYSICIAN ☐ NURSE PRACTITIONER ☐ PHYSICIAN ASSISTANT ☐ OPHTHALMOLOGIST ☐ 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. ☐ Yes ☐ 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)