Robert L. Quinn
Commissioner of Safety

State of New Hampshire
DEPARTMENT OF SAFETY
DIVISION OF MOTOR VEHICLES
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John C. Marasco
Director of Motor Vehicles

APPLICATION FOR MEDICAL WAIVER OF AFTER MARKET TINTING RESTRICTION

Directions: This application must be filled out and signed by a physician licensed to practice medicine in any state of the U.S. The applicant must return the completed application, along with a photocopy of the vehicle registration(s) (up to 2 vehicles), to the DMV for processing. If approved, a permit will be mailed to the applicant and will authorize tinting of the vehicles listed below, pursuant to RSA 266:61-a, IX and Administrative Rules Saf-C 2500.

Applicant Information:

Name: _____ Date of Birth: _____

Address: _____
Street *Town/City* *Zip*

Vehicle Information:

Plate Number: _____ _____ _____
Name of registered owner *Signature of registered owner*

Plate Number: _____ _____ _____
Name of registered owner *Signature of registered owner*

Signature of Applicant: _____ _____
(parent or guardian if applicant is a minor) This form is signed under penalty of unsworn falsification pursuant to NH law RSA 641:3 *Date*

The below information must be filled out by a physician licensed to practice medicine

Name and Description of Medical Condition: _____

Please state how after market tinting will alleviate the medical condition: _____

All certifications must be checked:

I certify that: ☐ Sunglasses or other protective equipment will **NOT** alleviate the medical condition.

I certify that: ☐ A tinted windshield or tinted windows to the left & right of the driver are recommended due to the applicant's medical condition.

I certify that: ☐ The applicant is under my treatment and care and in my professional opinion requires a medical waiver for window tinting as defined under RSA 266:58-a and Saf-C 2500.

☐ Check here if in your professional opinion the medical condition is likely to last at least 4 years (which would allow for a waiver for 4 years, instead of two).

Signature of Licensed Physician: _____ Date _____

Name of Physician: _____

Name of Practice: _____ Tele: _____

Address of Practice: _____
Street *Town/City* *Zip Code*