South Carolina Department of Motor Vehicles

Personalized License Plate for People who have a Disability

MV-96A
(04/2025)

Complete the application and mail it with the required fee to: **South Carolina Department of Motor Vehicles, 10311 Wilson Blvd., Building C, Blythewood, S.C. 29016-0038.**

- The plates are for cars or light trucks with an empty weight of 9,000 pounds or less and a gross vehicle weight of 11,000 pounds or less.
- Depending on your current expiration date, an updated tax receipt and additional fees may be required.
- The fee for a personalized plate is $30.00, non-refundable, plus the regular registration fee.
- Registration fees are as follows:
  Passenger Car - $30.00

Light Truck GVW Fees:

1 to -4000	$30.00	7001 to -8000	$80.00
4001 to -5000	$40.00	8001 to -9000	$90.00
5001 to -6000	$60.00	9001 to -10,000	$100.00
6001 to -7000	$70.00	10,001 to -11,000	$110.00

Section 1 – Information on Person who has a Disability

Last Name: _____ First Name: _____ Middle Name: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different): _____

All correspondence will be mailed to the address of the applicant.

City: _____ State: _____ Zip Code: _____

Update Voter Registration

Unless you indicate otherwise, the addresses above will be used by the State Election Commission to update your voter registration:
☐ Do not update my residence address. ☐ Do not update my mailing address.

(Area Code) Telephone Number: _____ Person's SC Driver License, BP, or ID Number: _____

Email Address: _____ Date of Birth: _____

Signature of Person | Printed Name of Person | Date

Section 2 – Vehicle Information

Vehicle Identification Number: _____ Make: _____ Year: _____

SC Driver License, BP, or ID Number: _____ Vehicle License Plate Number: _____

☐ I am applicant in Section 1 ☐ I certify that I am an immediate family member of the applicant.

☐ Yes, I wish to donate $5.00, more or less, to Donate Life S.C. Amount of donation $ _____.00

INSURANCE CERTIFICATION

Under penalties of perjury, I declare this vehicle is insured with _____ and I will maintain liability insurance throughout the registration period.
(Insurance Company)

Signature of Vehicle Owner | Printed Name of Vehicle Owner | Date

Section 3 – Medical Statement

A licensed physician, an Advance Practice Registered Nurse (APRN), or a Physician Assistant (PA) must complete this portion of the application and must indicate the disability and length of disability.

A licensed physician, APRN, or PA must certify the applicant has a disability.

This is to certify that _____ has the following condition(s):
Name of Applicant and Date of Birth (Please Print)

☐ an inability to ordinarily walk one hundred feet nonstop without aggravating an existing medical condition, including the increase of pain;

☐ an inability to ordinarily walk without the use of, or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device;

☐ a restriction by lung disease to the extent that the person's forced expiratory volume for one second when measured by spirometry is less than one liter, or the arterial oxygen tension is less than sixty mm/hg on room air at rest;

☐ requires use of portable oxygen;

☐ a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to standards established by the American Heart Association. If the person's status improves to a higher level, for example as a result of bypass surgery or transplantation, he no longer meets this criteria;

☐ a substantial limitation in the ability to walk due to an arthritic, neurological, or orthopedic condition, for example, coordination problems and muscle spasticity due to conditions that include Parkinson's disease, cerebral palsy, or multiple sclerosis; or

☐ blindness.

This disability is permanent. Physician, APRN, or PA Phone Number: _____

I certify that I am: ☐ a licensed physician ☐ an APRN ☐ a Physician Assistant

Print Name of Physician, APRN, or PA | Signature of Physician, APRN, or PA | State Professional License No. | Date

PERSONALIZED PLATE INFORMATION

Required: (Application will not be processed if not completed.) Please explain the meaning or relevance of text requested. Expand text for abbreviations.

_____

_____

Personalized Plate Choices:

1st								
2nd								
3rd								

DMV USE ONLY

Plate No. _____ Purchase Order _____ Specialist Initials _____