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

Application for CDL Disability Waiver or Hazardous Materials Variance

Valid in Virginia ONLY for Transporting Intrastate Freight, Property or Passengers.

Purpose: Use this form to apply for a CDL (Commercial Driver's License) disability waiver or hazardous materials variance. Waivers or variances are granted only for disabilities (1) (2) (3) and (10) listed in Federal Motor Carrier Safety Regulations FMCSA 49 C.F.R. Section (b) 391.41.

Instructions: Review Disability Types below and if you have disabilities (1), (2) or (3) complete this form and submit with a Customer Medical Report (MED 2) completed by your medical provider. If you have disability (10) complete this form and submit with a customer Vision Report (MED 4) completed by your medical provider. Send all completed forms to Medical Review Services at the above address.
If you have questions about completing this form, call Medical Review Services, (804) 367-6203.

APPLICATION TYPE

Check one
- ☐ New Application
- ☐ Renewal Application

Will your commercial motor vehicle (cmv) operation transport hazardous materials? ☐ YES ☐ NO

If YES - a Hazardous Materials Variance may be issued to authorize you to transport hazardous materials, general freight and property.

If NO - a Disability Waiver may be issued to authorize you to transport general freight, property or passengers.

I understand that if granted a waiver or variance, it would be valid only in Virginia for transporting intrastate freight, property or passengers and therefore I certify that my CMV operations will be:

☐ NA - Non-excepted Intrastate ☐ EA - Excepted Intrastate

This self certification is based upon the qualification requirements under Title 19 30-20-150 of the VA Administrative Code.

DISABILITY TYPES (Check type of disability for which you are applying for a waiver/variance)

- ☐ **(1)** Have loss of leg, foot, arm or hand.
- ☐ **(2)** Have impairment of hand or finger which interferes with prehension or power grasping.
- ☐ **(2)** Have impairment of arm, foot or leg which interferes with ability to perform normal operation of commercial vehicle.
- ☐ **(3)** Do not have distant visual acuity or horizontal vision - with or without corrective lenses - that meets FMCSA CDL requirements.
- ☐ **(10)** Have a history or clinical diagnosis of diabetes mellitus currently requiring insulin for control.

APPLICANT DRIVER INFORMATION

If you change either your residence address or mailing address to a non-Virginia address, your CDL driver's license or photo identification (ID) card may be canceled.

FULL LEGAL NAME (last)	(first)	(middle)	(suffix)

SOCIAL SECURITY NUMBER OR DRIVER LICENSE NUMBER	DAYTIME TELEPHONE NUMBER ( )	DATE OF BIRTH (mm/dd/yyyy)	
RESIDENCE ADDRESS ☐ CHECK HERE IF THIS IS A NEW ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS ☐ CHECK HERE IF THIS IS A NEW ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER INFORMATION

COMPANY NAME	CARRIER SCC/ID NUMBER OR U.S. DOT NUMBER	
AUTHORIZED REPRESENTATIVE NAME (print)	TELEPHONE NUMBER ( )	FAX NUMBER ( )

BUSINESS ADDRESS	CITY	STATE	ZIP CODE

EMPLOYMENT INFORMATION

DRIVER JOB DUTIES

EMPLOYMENT DATE (mm/dd/yyyy) _____ to _____	COMMODITY TO BE TRANSPORTED (check all that apply) ☐ General Freight ☐ Property ☐ Passengers ☐ Hazardous Materials (Complete 3 boxes below)	
YEARS OF EXPERIENCE HAULING HAZARDOUS MATERIALS	TYPE OF FREIGHT	TYPE OF HAZARDOUS MATERIALS

APPLICANT DRIVER AND CARRIER/COMPANY CERTIFICATION

I/We certify that the applicant is otherwise qualified pursuant to the Federal Motor Carrier Safety Regulations with the exception of the physical disability(ies) described in this application and if I/we are applying for a Variance I/we certify that I/we understand that the law requires me/us to notify DMV upon any change in employment.

I/we further certify and affirm that all information presented in this form is true and correct, that any documents I/we have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I/we make this certification and affirmation under penalty of perjury and I/we understand that knowingly making a false statement or representation on this form is a criminal violation.

DRIVER SIGNATURE	DATE (mm/dd/yyyy)
CARRIER/COMPANY AUTHORIZED REPRESENTATIVE SIGNATURE	DATE (mm/dd/yyyy)

APPLICANT NAME	DMV CUSTOMER NUMBER (as it appears on license

DISABILITIES (1), (2) - (This section to be completed by physician/physician assistant/nurse practitioner)

Applicant has missing or impaired limb(s).
Answer and complete questions **a** through **e.** Also complete the applicable sections of the Customer Medical Report (MED 2).

a. STRENGTH: Does the driver have adequate muscle strength to perform the tasks required? ☐ YES ☐ NO

If NO, indicate the impaired extremity.

Upper Extremity ☐ Right ☐ Left Lower Extremity ☐ Right ☐ Left

b. MOBILITY: Does the driver have adequate mobility of the extremities and trunk to perform the tasks required? ☐ YES ☐ NO

If NO, indicate the impaired extremity.

Trunk ☐ Upper Extremity ☐ Right ☐ Left Lower Extremity ☐ Right ☐ Left

c. STABILITY: Does the driver have adequate joints and trunk stability to perform the tasks required? ☐ YES ☐ NO

If NO, indicate the impaired extremity.

Trunk ☐ Upper Extremity ☐ Right ☐ Left Lower Extremity ☐ Right ☐ Left

d. PRECISION PREHENSION and POWER GRASP: If this driver has an upper limb impairment or is a partial hand or upper limb amputee, is the driver capable of demonstrating precision prehension (e.g., turning knobs, switches, etc.) and power grasp (e.g., holding and maneuvering the steering wheel) with each upper limb separately?

Right Hand ☐ Yes ☐ No Left Hand ☐ Yes ☐ No

If NO, do you recommend a surgical reconstruction to produce power grip and/or prehension? ☐ YES ☐ NO

e. AMPUTEE: Does the driver have:

- the appropriate type of prosthesis? ☐ YES ☐ NO
- If yes, does the prosthesis fit satisfactorily, and is it in good operating condition? ☐ YES ☐ NO
- the appropriate type of terminal device? ☐ YES ☐ NO

If NO to any of these what is your recommendation?

DISABILITY (3) - (This section to be completed by physician/physician assistant/nurse practitioner)

Does the applicant have diabetes or any other metabolic condition(s) that might affect operation of a commercial motor vehicle?
☐ YES ☐ NO If YES, also complete applicable sections of Customer Medical Report (MED 2).

DISABILITY (10) - (This section to be completed by ophthalmologist/optometrist)

Does the applicant have any visual defects, condition or field loss that would affect the safe operation of a commercial motor vehicle?
☐ YES ☐ NO If YES, also complete a Customer Vision Report (MED 4).

Federal Motor Carrier Safety Regulations FMCSA 49 C.F.R. Section (b)(10) 391.41 requires distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70 degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, green, and amber.

MEDICAL PROVIDER CERTIFICATION

Based on my examination, this applicant is capable of safely operating a commercial motor vehicle - which includes operating tractor trailers, passenger buses, tank vehicles, school buses for 16 or more occupants (including the driver), or vehicles carrying hazardous materials.

I further certify and affirm that to the best of my knowledge and belief, all information I have 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.

CHECK BOX THAT APPLIES: ☐ PHYSICIAN ☐ PHYSICIAN ASSISTANT ☐ NURSE PRACTITIONER ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST

MEDICAL PROVIDER NAME (print)	MEDICAL LICENSE NUMBER	STATE ISSUING MEDICAL LICENSE	EXPIRATION DATE (mm/dd/yyyy)

BUSINESS ADDRESS				
CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )	FAX NUMBER ( )

MEDICAL PROVIDER SIGNATURE	DATE (mm/dd/yyyy)