

azdot.gov

40-1511 R03/20

## APPLICATION FOR WINDOW TINT MEDICAL EXEMPTION

Arizona Revised Statute (A.R.S.) §28-959.01

Please submit the completed application to <a href="MedicalReview@azdot.gov">MedicalReview@azdot.gov</a> or PO Box 2100, Mail Drop 818Z, Phoenix, AZ 85001

For additional questions please contact Medical Review Program at 602-771-2460

1.								
2. Full printed name of the person with the me	dical condition							
Name (first, middle, last, suffix) – please print			Date	Date of Birth		Customer Number		
Street Address		City		•		State	Zip Code	
Mailing Address (If different from above)		City				State	Zip Code	
Email (optional)		1						
3. Vehicle information of person with the medi	cal condition re	equesti	ng wind	ow tint	exempt	ion		
Vehicle Identification Number (VIN)	Year		Make/Model		Plate Number			
Vehicle Identification Number (VIN)	Year	Make/Model		lel	Plate N		ımber	
4. If you are a habitual passenger of the vehicl	e, please have	registe	ered own	er com	plete Se	ction 4		
Name (First, Middle, Last ) – please print					Customer Number			
Street Address		City				State	Zip Code	
Vehicle Identification Number (VIN)	Year		Make/Mod	lel		Plate Number		
Signature of vehicle owner					Date			
5. Medical Provider Certification								
I have personally examined the above applicant or habitual required to be shielded from the direct rays of the sun, and	-							
ARS § 28-959.01, substance or material in conjunction w luminous reflectance of 35% plus or minus 3% may be ap			_			-		
only applies to the driver side windows, passenger side wi	ndows, back wind	ow and	the top of	the man	ufacturer's	AS-1 lin	e. (Tinting does not	
apply to the front windshield)								
Print/Type Name of Certifying Authority				MD/DO or Ophthalmologist State License Number ( <b>Required</b> )				
Business Address	City		State Zip Coo		ı	Telephone Number		
Medical Provider Signature					Date			