



STATE OF RHODE ISLAND

**DIVISION OF MOTOR VEHICLES  
ADJUDICATION OFFICE**

600 New London Avenue  
Cranston, RI 02920-3024

Phone: 401-462-0800 Fax: 401-462-0829  
www.dmv.ri.gov

**APPLICATION FOR MEDICAL EXEMPTION FROM  
MAXIMUM WINDOW TINT LIMITS**

APPLICANT must be a Rhode Island resident. The original application (no faxes) must be submitted within thirty (30) days of the physician's affidavit. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

**NOTE: The information required in this application may affect your license status. Additional documentation may be required.**

Lease Vehicle(s): If your vehicle is leased, there must be an accompanying letter from the leasing company authorizing the tint.

I hereby authorize the physician completing this form to discuss and release to the Division of Motor Vehicles any and all of my medical records necessary to assess my application.

**Applicant must provide the following information (PLEASE PRINT):**

Applicant's Full Name: \_\_\_\_\_

Residence Address: \_\_\_\_\_  
NUMBER & STREET CITY/TOWN STATE ZIP CODE

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Occupation \_\_\_\_\_ License Number: \_\_\_\_\_

Vehicle(s) requested to tint:

Registration # \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ VIN # \_\_\_\_\_

Registration # \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ VIN # \_\_\_\_\_

Registration # \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ VIN # \_\_\_\_\_

**NOTICE: It is a misdemeanor to knowingly make false statements, and is punishable by fines up to \$1,000.00 or up to one year in jail. Rhode Island General Law §11-18-1.**

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

Subscribed and sworn to before me in \_\_\_\_\_ in the County of \_\_\_\_\_ in the State of Rhode Island and Providence Plantations, this \_\_\_\_\_ day of \_\_\_\_\_ A.D. 20\_\_\_\_.

\_\_\_\_\_  
**Notary Public**

**Instructions to physician/optometrist are on reverse side**

Dear Physician/Optometrlist:

The applicant listed on this form is applying for an exemption from complying with the maximum limits allowed in state law for motor vehicle window tinting. Approval of this application will allow the individual to tint his/her window darker than is allowed by state law. In answering the following questions, please keep in mind that darkening on the motor vehicle can pose a threat to public safety personnel. No exception shall be granted for any condition for which protection from the direct rays of the sun can be adequately provided by the use of a quality pair of sun glasses unless said condition is deemed medically necessary.

Are you the patient's primary physician/optometrist?  Yes  No If so, for how long? \_\_\_\_\_

Please explain in detail the patient's condition:

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Please provide your medical opinion on why decreasing the light transmittance to the motor vehicle is medically necessary, and why a quality pair of sun glasses is not an adequate medical alternative?

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State and Federal law require tinted windows to have a minimum total visibility light transmittance of not less than seventy percent (70%). If you deem it medically necessary to darken the windows of your patient's motor vehicle, what percentage less than seventy percent (70%) of light transmittance would address you patient's medical needs?

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Is the applicant's condition permanent or temporary, and if temporary, for how long?

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**Affidavit by Physician or Optometrist**

I, \_\_\_\_\_, am a(n)  Physician  Optometrist licensed to practice in this state and I MAKE OATH AND SAY that \_\_\_\_\_ has a physical condition that makes it necessary to equip the vehicle registered by him/her with tinted windows that exceed the State limit.

PLEASE PRINT NAME

Signature: \_\_\_\_\_ Medical License #: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR DIVISION OF MOTOR VEHICLE USE ONLY**

\_\_\_\_ Approved Date: \_\_\_\_\_ Permit #: \_\_\_\_\_

\_\_\_\_ Disapproved Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_