Dear Sir/Madam:

Thank you for your interest in the tinted window permit. The waiver process gives a person, who suffers from a medical condition that results in photosensitivity to visible light, the opportunity to obtain a window medical exception permit from the Division of Motor Vehicles. Please have your physician complete the enclosed form and return it to:

    NC Division of Motor Vehicles
    Medical Review Unit
    3112 Mail Service Center
    Raleigh, North Carolina 27699-3112

Your application will be reviewed when we receive it and you will receive a decision in the mail. Feel free to contact a member of my staff at (919) 861-3809 should you have any questions.

Sincerely,

Director of Customer Compliance Services
Division of Motor Vehicles

Enclosure
NORTH CAROLINA DIVISION OF MOTOR VEHICLES
TINTED WINDOW WAIVER APPLICATION FORM

Applicant to complete the information in sections 1, 2, 3, and 4
Physician to complete section 5

1

☐ New  ☐ Renewal

Applicant’s Name: ___________________________ Date ___________________________

Driver’s License # ___________________________ SSN: ___________________________

Street Address: _____________________________

City ___________________________ State ___________________________ Zip Code ___________________________ Date of Birth ___________________________

Vehicle 1

2

Vehicle tag number ___________________________ Vehicle identification number ___________________________

Owner Name: _____________________________

Owner Address: _____________________________

Vehicle 2

3

Vehicle tag number ___________________________ Vehicle identification number ___________________________

Owner Name: _____________________________

Owner Address: _____________________________

Consent for release of medical information

I, the undersigned, hereby authorize Dr. ___________________________ to give any examination deemed necessary for the purpose of determining my exception. I give permission to this physician, and other physicians, clinics, or hospitals involved in my care, to share records and discuss my medical condition with each other and with the Division of Motor Vehicles. If requested, I agree to release to the Division of Motor Vehicles or its representatives any information concerning my condition, and any or all the information provided to my doctor. I do hereby release, waive, and relinquish all claims against the Division of Motor Vehicles, its agents and employees, for any cause whatsoever arising out of the release of this medical information.

Signature of Applicant: ___________________________

Parent/Guardian if minor: ___________________________
To the examining physician:

Currently, General Statutes 20-127 (b) provides for tinting along the top of the windshield, not to exceed five inches below the top of the windshield or below the AS1 line, whichever is longer. In addition all other windows may be tinted up to 20%. Effective July 1, 2001, an applicant with medical certification from their physician will be eligible through the Division of Motor Vehicles to have a maximum tinting of visible light transmission of 70% to the windshields.

Yes, I certify that the above patient suffers from a medical condition that is sensitive to visible light such being:

________________________________________________________________________

Please indicate the number of years you recommend this permit be issued:
(circle one)

2  3  4  5

Physician’s Name: (Print) ________________________________________________

Physician’s Specialty: ____________________________________________________

Physician’s Signature: __________________________________ Date: ___________

Address ________________________________________________________________

State __________ Zip Code __________ Phone No. _________________________

Note: Cannot be processed if not completely filled out.