



STATE OF NORTH CAROLINA  
DEPARTMENT OF TRANSPORTATION  
DIVISION OF MOTOR VEHICLES

PAT MCCRORY  
GOVERNOR

NICHOLAS J. TENNYSON  
SECRETARY

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  
Hearings Section  
Medical Review Unit  
3112 Mail Service Center  
Raleigh, NC 27699-3112  
Fax #: (919) 733-9569

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,

A handwritten signature in black ink, appearing to read "JR Zimmerman", with a long horizontal line extending to the right.

Jeffrey R. Zimmerman, M.P.A.  
Director of Processing Services  
Division of Motor Vehicles

Enclosure

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**MAILING ADDRESS:**  
NC DIVISION OF MOTOR VEHICLES  
HEARINGS SECTION  
MEDICAL REVIEW UNIT  
3112 MAIL SERVICE CENTER  
RALEIGH NC 27699-3112

TELEPHONE: 919-715-7000  
WEBSITE: [WWW.NCDOT.GOV/DMV](http://WWW.NCDOT.GOV/DMV)

**LOCATION:**  
DMV HEADQUARTERS BUILDING  
1100 NEW BERN AVENUE  
RALEIGH NC

# 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

**4** I, the undersigned, hereby authorize Dr. \_\_\_\_\_ 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:**

**5**

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 Speciality: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone No. \_\_\_\_\_

***Note: Cannot be processed if not completely filled out.***