STATE OF NORTH CAROLINA
DEPARTMENT OF TRANSPORTATION

JOSH STEIN
GOVERNOR

J.R. "JOEY" HOPKINS
SECRETARY

Dear Customer:

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

You may also fax this information to the Division at (919) 861-3284, (919) 733-9569 or (919) 861-3836 as soon as possible to expedite the processing of your application.

Please 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

Mailing Address:
NC DIVISION OF MOTOR VEHICLES
CUSTOMER COMPLIANCE SERVICES
MEDICAL REVIEW UNIT
3112 MAIL SERVICE CENTER
RALEIGH, NC 27699-3112

Telephone: (919) 715-7000

Website: www.ncdot.gov

Location:
DMV HEADQUARTERS BUILDING
1515 N. CHURCH STREET
ROCKY MOUNT, NC 27804

Rev. 5/2024

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 License: _____ Phone Number: _____ Date of Birth: _____

Street Address: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____

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: _____

5 **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 a 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 Number: _____

Note: Incomplete Forms Will Not Be Processed