

MV-402 (01-02)

Commonwealth of Pennsylvania
Department of Transportation
Vehicle Inspection Division
P.O. Box 68697
Harrisburg, PA 17106-8697

**APPLICATION FOR
SUN SCREENING
CERTIFICATE OF EXEMPTION****THE FOLLOWING QUESTIONS ARE TO BE ANSWERED BY THE APPLICANT**

1. Full Name _____ Daytime Telephone # _____
2. Street Address _____
City _____ State _____ Zip Code _____
3. Vehicle for which application is being made. Make _____ Year _____
VIN _____ Registration Plate _____
Title Number _____
4. Windows with after market sun screening for which a certificate of exemption is requested:

"PLACE X WHERE NEEDED"

Windshield _____

Driver Side: Left Front _____

Left Rear _____

Passenger Side: Right Front _____

Right Rear _____

On vans, station wagons and buses list the number of additional rear side windows:

Number of additional passenger side right-rear windows: _____

Number of additional driver side left-rear windows: _____

5. When did you purchase this vehicle? Date _____ / _____ / _____
Month Day Year
6. When was the sun screening installed? Date _____ / _____ / _____
Month Day Year
- 6a. If unknown, was sun screening installed prior to your ownership of the vehicle? Yes _____ No _____
7. When was this vehicle first registered by you in Pennsylvania? Date _____ / _____ / _____
Month Day Year
8. What is the serial number of the current inspection sticker displayed on this vehicle? Number _____

I certify under penalty of law that the above facts are true and correct to the best of my knowledge and that the vehicle is equipped with the after market sun screening as indicated.

Vehicle Owner's Signature _____ Date _____

(When vehicle is registered in more than one name, all signatures must appear above.)

REQUEST FOR MEDICAL EXEMPTION

This portion must be completed by a licensed physician or optometrist when a certificate of exemption is requested due to a physical condition.

(Please type or print)

PATIENT INFORMATION

Patient Name _____ Daytime Telephone # _____

Street Address _____

City _____ State _____ Zip Code _____

Brief Description of patients condition: _____

Suggested Treatment(s): _____

PHYSICIAN/OPTOMETRIST INFORMATION

Physician/Optometrist Name _____

Business Affiliation (if any) _____

Business Address _____

City _____ State _____ Zip Code _____

I certify under penalty of law that the above facts are true and correct to the best of my knowledge:

Signature _____ Date _____

THE REVERSE SIDE MUST BE COMPLETED BY THE VEHICLE OWNER