EXHIBIT 1
For Federal civil complaint
Brian David Hill v. Executive Office
for United States Attorneys (EOUSA),
United States Department of Justice
(U.S. DOJ)
**DISABLED PARKING PLACARDS OR LICENSE PLATES APPLICATION**

**Purpose:** Use this form to apply for a disabled parking placard or disabled parking license plates.

**Instructions:** Submit to any Customer Service Center, DMV Select or mail to DMV, Data Integrity, P.O. Box 85815, Richmond, VA 23286-6815.
- For a parking placard, submit this form with a $5.00 check or money order payable to DMV. Placard will be mailed to you in approximately 15 days. Only one placard may be issued to a customer.
- For disabled parking license plates, submit this form, a License Plate Application (VSA 10) and applicable fees.

### DISABLED PARKING PLACARD ONLY

<table>
<thead>
<tr>
<th>CHECK ONE</th>
<th>PERMANENT (5 years)</th>
<th>PERMANENT REPLACEMENT (5 years)</th>
<th>TEMPORARY (up to 6 months)</th>
<th>TEMPORARY REPLACEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ Original (medical professional certification required)</td>
<td>☐ Lost</td>
<td>☐ Stolen</td>
<td>☐ Original</td>
<td>☐ Lost</td>
</tr>
<tr>
<td>☐ Renewal (No medical professional certification required)</td>
<td>☐ Destroyed</td>
<td>☐ Mutated</td>
<td>☐ Destroyed</td>
<td>☐ Stolen</td>
</tr>
<tr>
<td>☐ Reissue</td>
<td>☐ Reissue</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DISABLED PARKING (HP) LICENSE PLATES ONLY

<table>
<thead>
<tr>
<th>ORIGINAL PLATES</th>
<th>DUPLICATE</th>
<th>REISSUE</th>
<th>UNREADABLE (License-plate letters or numbers unclear)</th>
<th>NEVER RECEIVED LICENSE PLATES</th>
<th>CHECK THIS BOX IF THIS VEHICLE IS SPECIFICALLY EQUIPPED AND USED FOR TRANSPORTING GROUPS OF PHYSICALLY DISABLED PERSONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Complete and submit form VSA 10</td>
<td>☐ Lost</td>
<td>☐ Destroyed</td>
<td>☐ Never received license plates</td>
<td>☐ Original</td>
<td>☐ Lost</td>
</tr>
<tr>
<td>☐ Unreadable</td>
<td>☐ Reissue</td>
<td>☐ Mutated</td>
<td>☐ Never received license plates</td>
<td>☐ Original</td>
<td>☐ Stolen</td>
</tr>
</tbody>
</table>

**VEHICLE IDENTIFICATION NUMBER (VIN):**

**TITLE NUMBER:**

☐ I am the vehicle owner and the parent/legal guardian of a disabled dependent(s). List the name of each disabled person below.

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**APPLICANT INFORMATION**

<table>
<thead>
<tr>
<th>FULL LEGAL NAME (last)</th>
<th>(first)</th>
<th>(middle)</th>
<th>(suite)</th>
<th>DMV ASSIGNED NUMBER OR SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>HILL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAVID</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CURRENT RESIDENCE ADDRESS</th>
<th>☐ Check here if this is a new address.</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>310 Forest St, Apt. 2</td>
<td></td>
<td></td>
<td></td>
<td>24112</td>
</tr>
<tr>
<td>Martinsville</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CITY OR COUNTY OF RESIDENCE</th>
<th>DAYTIME TELEPHONE NUMBER OR CELL PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martinsville</td>
<td>276-790-3505</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAILING ADDRESS (different from above)</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>BIRTH DATE (mm/dd/yyyy)</th>
<th>GENDER</th>
<th>HAIR COLOR</th>
<th>EYE COLOR</th>
<th>HEIGHT</th>
<th>WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MALE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FEMALE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**APPLICANT CERTIFICATION**

I understand that misuse, counterfeiting, or alteration of disabled placards may result in fines up to $1000. and up to 6 months in jail and/or revocation of disabled parking privileges. I certify that I have a (check one): ☐ Temporary ☑ Permanent disability that limits or impairs my ability to walk or creates a safety concern while walking.

I also understand that the disabled parking placard or plates issued to me cannot be loaned to anyone, including family members or friends, to benefit a person other than myself.

I further certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

**APPLICANT SIGNATURE:**

**DATE:**

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MEDICAL PROFESSIONAL NAME: BALAKRISHNAN

LICENSE TYPE: MD

DATE (mm/dd/yyyy): 01/31/16

LICENSE NUMBER: (required)

STATE ISSUING LICENSE: VA

LICENSE EXPIRATION DATE (mm/dd/yyyy): (required)

MEDICAL PROFESSIONAL SIGNATURE:

LICENSED PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER MEDICAL CERTIFICATION

Permanently limited or impaired. A permanent disability as it relates to disabled parking privileges shall mean: a condition that limits or impairs movement from one place to another or the ability to walk as defined in Virginia Code §46.2-1240, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.

Reason this patient's ability to walk is limited or impaired or creates a safety condition while walking. (Check below)

☐ Cannot walk 200 feet without stopping to rest.

☐ Uses portable oxygen.

☐ Cannot walk without the use of or assistance from any of the following: another person, brace, cane, crutch, prosthesis device, wheelchair; or other assistive device.

☐ Has a cardiac condition to the extent that functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.

☐ Is restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 millimeters of mercury on room air at rest.

☐ Is severely limited in ability to walk due to an arthritic, neurological, or orthopedic condition.

I certify and affirm that the described applicant is my patient, whose ability to walk, based on my examination, is limited or impaired or creates a safety concern while walking as described above.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

MEDICAL PROFESSIONAL NAME:

LICENSE TYPE:

LICENSE NUMBER: (required)

STATE ISSUING LICENSE: VA

LICENSE EXPIRATION DATE (mm/dd/yyyy): (required)

MEDICAL PROFESSIONAL SIGNATURE:

LICENSED CHIROPRACTOR OR PODIATRIST MEDICAL CERTIFICATION

Permanently limited or impaired. A permanent disability as it relates to disabled parking privileges shall mean: a condition that limits or impairs movement from one place to another or the ability to walk as defined in Virginia Code §46.2-1240, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.

Reason this patient's ability to walk is limited or impaired or creates a safety condition while walking. (Check below)

☐ Cannot walk 200 feet without stopping to rest.

☐ Uses portable oxygen.

☐ Cannot walk without the use of or assistance from any of the following: another person, brace, cane, crutch, prosthesis device, wheelchair; or other assistive device.

☐ Is severely limited in ability to walk due to an arthritic, neurological, or orthopedic condition.

I certify and affirm that the described applicant is my patient, whose ability to walk, based on my examination, is limited or impaired or creates a safety concern while walking as described above.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.
Hill, Brian (MRN 7244793)  

Patient Preferred Name  
No data filed  

Basic Information  

Date of Birth: 5/26/1990  
Sex: Male  
Race: White or Caucasian  
Ethnicity: Non-Hispanic  
Preferred Language: English  

Department  

Name: Carillion Clinic, Endocrinology  
Address: 3 Riverside Circle Roanoke VA 24016  
Phone: 540-224-5170  
Fax: 540-983-8229  

Reason for Visit  

Follow-up  
Diabetes: Type 1  
Reason for Visit History  

Your Vitals Were  

<table>
<thead>
<tr>
<th>BP</th>
<th>Pulse</th>
<th>HT</th>
<th>WT</th>
<th>BMl</th>
<th>Smoking Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>132/78 mmHg</td>
<td>89</td>
<td>1.753 m (5' 9&quot;)</td>
<td>92.126 kg (203 lb 1.6 oz)</td>
<td>29.98 kg/m2</td>
<td>Never Smoker</td>
</tr>
</tbody>
</table>

To Do List  

Friday September 02, 2016  
10:45 AM  
Appointment with Herodotou, Demetrios at Carillion Clinic, Endocrinology  
(540-224-5170)  
3 Riverside Circle  
Roanoke VA 24016  

Pending Health Maintenance  

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date Due</th>
<th>Completion Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDAP IMMUNIZATION</td>
<td>5/26/2001</td>
<td></td>
</tr>
<tr>
<td>DIABETIC FOOT EXAM</td>
<td>5/26/2008</td>
<td></td>
</tr>
<tr>
<td>DIABETIC EYE EXAM</td>
<td>5/26/2008</td>
<td></td>
</tr>
</tbody>
</table>

Allergies  

Anesthetic [Benzocaine-Aloe Vera]  
Other - See Comments  

Vaccine Adjuvant Emulsion Combination No. 1  
Resident stated he gets out of control  

Zantac [Ranitidine HCl]  
Diarrhea  

Your Current Medications Are  

- insulin aspart (NOVOLOG FLEXPEN) 100 unit/mL Insulin Pen (Taking)  
  10 Units by Subcutaneous route as directed for Other (follow the sliding scale.)  
- insulin glargine (LANTUS) 100 unit/mL Solution (Taking)  
  36 Units by Subcutaneous route every night  
- omeprazole (PRILOSEC OTC) 20 mg Tablet, Delayed Release (E.C.) (Taking)  
  take 1 Tab by mouth every day  
- BD INSULIN SYRINGE ULTRA-FINE 0.5 mL  
  31 gauge x 5/16 Syringe  
  1 Each by Subcutaneous route four times daily  
- BD INSULIN PEN NEEDLE UF MINI 31 X 3/16" (BD INSULIN PEN NEEDLE UF MINI)  
  1 Each by Subcutaneous route four times daily
**Your Current Medications Are (continued)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 gauge x 3/16&quot; Needle</td>
<td>1</td>
<td>Insulin Needles, Disposable, (BD INSULIN PEN NEEDLE UF SHORT) 31 gauge x 5/16&quot; Needle</td>
</tr>
<tr>
<td>glucose blood VI test strips (FREESTYLE INSULINX TEST STRIPS) Strip</td>
<td>1</td>
<td>Strip by external route three times daily</td>
</tr>
<tr>
<td>Blood-Glucose Meter (ACCU-CHEK AVIVA PLUS METER) Misc</td>
<td>1</td>
<td>Device by Does not apply route three times daily</td>
</tr>
<tr>
<td>Insulin Syringe-Needle U-100 (BD INSULIN SYRINGE ULTRA-FINE) 1 mL 30 x 1/2&quot; Syringe</td>
<td>1</td>
<td>Each by Does not apply route four times daily</td>
</tr>
</tbody>
</table>

**Pharmacy**

WALGREENS DRUG STORE 12495 - MARTINSVILLE, VA - 2707 GREENSBORO RD AT NWC OF RIVES & US 220  
2707 GREENSBORO RD MARTINSVILLE VA 24112-9104  
Phone: 276-632-0180 Fax: 276-632-6759  
Open 24 Hours?: No