[Physician Name, MD/DO]
[Clinic/Hospital Name]
[Medical Office Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Recipient Name or Department]
[Department of Motor Vehicles / Parking Authority]
[Address]
[City, State, Zip Code]

RE: Medical Necessity for Accessible Parking Permit for [Patient Name]

To Whom It May Concern,

I am the treating physician for [Patient Name], born on [Patient Date of Birth]. I am writing this letter to formally support their application for a [Permanent/Temporary] disabled parking permit.

[Patient Name] has a diagnosed medical condition that significantly limits their mobility. Specifically, the patient meets the following criteria:

- Cannot walk 200 feet without stopping to rest.
- Cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device.
- Is restricted by lung disease or cardiovascular condition to a specific functional capacity.
- [Optional: Insert specific medical justification or duration of disability here].

Due to these physical limitations, it is medically necessary for the patient to have access to parking spaces located in close proximity to building entrances to minimize physical exertion and ensure their safety.

I certify that the information provided above is true and accurate to the best of my knowledge. Please process this request for an accessible parking placard accordingly.

If you require any further medical documentation or clarification, please contact my office at [Phone Number].

Sincerely,

[Signature of Physician]

[Printed Name of Physician]
[Medical License Number]
[State of Licensure]