

**Date:** [Insert Date]

**To:** [Insert Department of Motor Vehicles / Local Authority Name]

**Address:** [Insert Address]

**Subject: Medical Certification for Temporary Disabled Parking Placard**

To Whom It May Concern,

I am writing to formally certify that my patient, **[Patient's Full Name]**, born on **[Patient's Date of Birth]**, is under my professional care and currently has a mobility impairment that qualifies for a temporary disabled parking placard.

**Medical Condition/Justification:**

The patient is experiencing [Briefly describe condition, e.g., recovery from surgery/limited mobility] which severely restricts their ability to walk [Insert distance, e.g., 200 feet] without the use of an assistive device or experiencing significant distress.

**Estimated Duration:**

This disability is temporary in nature. I recommend the issuance of a temporary placard for a period of [Number] months, beginning on [Start Date] and expiring on [End Date].

If you require any further information or verification regarding this request, please contact my office at [Phone Number].

Sincerely,

**Signature:** \_\_\_\_\_

**Physician Name:** [Insert Printed Name]

**Medical License #:** [Insert License Number]

**Clinic/Hospital Name:** [Insert Name]

**Phone Number:** [Insert Phone Number]