Date: [Date]

To: Department of Motor Vehicles / Parking Authority
From: [Physician's Full Name]
Clinic/Hospital: [Facility Name]
Subject: Medical Certification for Temporary Disabled Parking Placard

To Whom It May Concern,

This letter serves to certify that my patient, **[Patient Full Name]** (Date of Birth: [DOB]), is currently under my care following a surgical procedure performed on [Date of Surgery].

Due to the nature of the surgery and the subsequent recovery process, the patient's mobility is significantly impaired. Specifically, the patient is unable to walk 200 feet without stopping to rest and/or requires the use of an assistive device (crutches, walker, or wheelchair) during the healing period.

I am requesting a **temporary** disabled parking placard for a period of [Number] months to assist with the patient's safe access to medical follow-ups and essential activities during their rehabilitation.

Physician Signature: ___________________________
License Number: [License Number]
Phone Number: [Phone Number]