

Date: [Date]

To: [Department of Motor Vehicles / Licensing Agency Address]

Subject: Medical Certification for Permanent Disabled Parking Placard

Patient Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Patient Address: [Patient Home Address]

To Whom It May Concern,

I am the primary healthcare provider for the patient named above. I am writing to formally certify that this individual has a permanent disability involving a chronic mobility issue that significantly limits their ability to walk.

According to the criteria established by [State/Province] law, the patient qualifies for a disabled parking placard due to the following condition(s):

- Inability to walk 200 feet without stopping to rest.
- Severe restriction in mobility due to an arthritic, neurological, or orthopedic condition.
- Requirement of a brace, cane, crutch, wheelchair, or other assistive device for locomotion.
- [Optional: Specify other chronic medical reason].

The aforementioned mobility impairment is permanent and is not expected to improve. Therefore, I recommend the issuance of a permanent disabled parking placard to ensure the patient has accessible entry to facilities and to mitigate the physical strain of long-distance walking.

Should you require further medical documentation or verification, please contact my office at [Phone Number].

Sincerely,

Physician Name: [Name and Title]

Medical License Number: [License #]

Clinic/Hospital Name: [Name of Practice]

Signature: _____