

[Doctor's Name/Clinic Name]
[Medical Suite/Department]
[Street Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To: Department of Motor Vehicles / Primary Licensing Authority

RE: MEDICAL CERTIFICATION FOR DISABLED PARKING PLACARD

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]

To Whom It May Concern,

I am a licensed orthopedic physician currently treating [Patient Name] for a documented orthopedic condition that severely limits their functional mobility.

The patient meets the legal criteria for a disabled parking placard due to the following medical necessity:

- The patient cannot walk [Number, e.g., 200] feet without stopping to rest.
- The patient's mobility is restricted by orthopedic, neurological, or arthritic conditions.
- The patient requires the use of an assistive device (braces, cane, crutches, walker, or wheelchair).

Based on my clinical evaluation, I recommend the issuance of a:

- Temporary Placard:** Valid until [Date] for recovery from [Surgery/Injury].
 Permanent Placard: Due to a permanent disability or chronic condition.

Please process this request in accordance with state regulations to ensure the patient has accessible parking to safely attend medical appointments and perform daily activities.

Sincerely,

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