Date: [Insert Date]

To: [Insert Department of Motor Vehicles / State Agency Name]
From: [Insert Physician's Full Name and Title]
Subject: Medical Certification for Disabled Parking Placard

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Patient DOB]

To Whom It May Concern,

I am the primary treating physician for [Insert Patient Name]. I am writing to certify that this patient has been diagnosed with a permanent neurological condition that significantly limits their mobility and functional capacity.

The patient's condition results in the following mobility restrictions:

- Inability to walk [Insert Distance, e.g., 200 feet] without stopping to rest.
- Significant impairment in balance, coordination, or gait.
- The requirement of an assistive device (cane, walker, or wheelchair) for safe movement.
- Severe limitation in the ability to navigate parking lots safely due to neurological symptoms.

Based on these medical findings, I am authorizing the issuance of a [Permanent/Temporary] disabled parking placard for this patient. The estimated duration of this mobility limitation is [Insert Duration or "Permanent"].

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

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]
[Clinic/Hospital Name]
[Clinic Address]
[Clinic Phone Number]