Date: [Date]

To: [Department of Motor Vehicles / Relevant Authority]

Subject: Medical Certification for Disabled Parking Placard

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Patient Address: [Patient Address]

To Whom It May Concern,

I am the primary healthcare provider for [Patient Name]. This letter serves to formally certify that the patient suffers from a diagnosed cardiopulmonary disease that significantly limits their functional mobility.

The patient meets the medical criteria for a disabled parking placard due to the following condition(s):

- The patient is severely limited in their ability to walk due to an arthritic, neurological, or orthopedic condition.
- The patient suffers from a respiratory disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 mm/hg on room air at rest.
- The patient suffers from Class III or Class IV cardiac functional capacity according to standards set by the American Heart Association.

Based on this clinical assessment, I recommend that the patient be issued a [Permanent / Temporary] disabled parking placard. [If temporary, specify duration: e.g., 6 months].

Should you require any further medical documentation or clarification, please do not hesitate to contact my office.

Sincerely,

[Physician Signature]

Physician Name: [Name and Credentials]
Medical License Number: [License #]
Clinic/Hospital Name: [Facility Name]
Phone Number: [Phone Number]