

[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To the Department of Motor Vehicles (DMV),

RE: Medical Certification for Disabled Parking Placard
Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

I am writing to formally certify that [Patient Name] is a patient under the geriatric care of [Clinic Name]. Following a medical evaluation, I have determined that the patient meets the statutory requirements for a disabled person parking permit due to the following condition(s):

[Select applicable conditions: Limited mobility due to use of assistive device / Lung disease / Cardiac condition / Orthopedic or Neurological impairment / Legal blindness].

The patient's mobility is severely restricted, specifically: [Optional: e.g., Patient cannot walk 200 feet without stopping to rest].

I recommend that the patient be issued a [Permanent / Temporary] parking placard. [If temporary, specify duration: Valid until Date].

Please feel free to contact our office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[NPI Number]