

[Doctor's Name/Practice Name]

[Medical Clinic Address]

[City, State, Zip Code]

[Phone Number]

[Date]

To: Department of Motor Vehicles / Office of Personnel Services

RE: Authorization for Disabled Person Parking Placard

Patient Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Parent/Guardian Name: [Guardian Full Name]

To Whom It May Concern,

I am the primary healthcare provider for [Patient Name]. This letter is to certify that the patient has a diagnosed medical condition that severely limits their mobility and necessitates the use of a disabled person parking placard.

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

[Insert brief description of mobility impairment, e.g., inability to walk 200 feet without rest, requirement of assistive device, or severe respiratory/cardiac condition].

I am recommending a [Temporary / Permanent] parking placard for this patient. [If temporary, specify duration: e.g., 6 months].

The use of this placard is essential to ensure the patient's safety and to provide accessible entry to medical appointments and daily activities.

Should you require any further information, please contact my office at [Phone Number].

Sincerely,

[Signature of Physician]

[Printed Name of Physician]

[Medical License Number]

[NPI Number]