

Date: [Insert Date]

To: [Department of Motor Vehicles / Relevant Authority]

Address: [Street Address, City, State, Zip Code]

Subject: Medical Certification for Disabled Parking Placard

To Whom It May Concern,

I am writing to formally certify that my patient, **[Patient Name]**, born on **[Patient Date of Birth]**, is under my professional care and has been diagnosed with a permanent visual impairment.

The patient's condition meets the legal criteria for a disabled parking placard as defined by state regulations. Specifically, the patient's visual acuity is **[Insert Measurement, e.g., 20/200 or less]** in the better eye with correcting lenses, or they have a field of vision no greater than **[Insert Degrees]** degrees.

Due to this impairment, the patient requires the use of a disabled parking placard to ensure their safety and accessibility when traveling as a passenger. I recommend the issuance of a **[Permanent/Temporary]** placard for this individual.

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

Sincerely,

[Doctor Signature]

[Doctor Name, Title]

[Medical License Number]

[Clinic/Hospital Name]

[Phone Number]