

Date: [Insert Date]

To: Department of Motor Vehicles / Physical Rehabilitation Board

Subject: Medical Authorization for Disabled Parking Placard

Patient Name: [Insert Patient Full Name]

Date of Birth: [Insert Date of Birth]

Patient ID/Record Number: [Insert ID Number]

To Whom It May Concern,

I am writing to formally authorize and recommend the issuance of a disabled parking placard for the above-named patient, who is currently under my care for physical rehabilitation services.

The patient presents with the following mobility limitations:

- [Insert specific condition, e.g., inability to walk 200 feet without stopping to rest]
- [Insert specific condition, e.g., requirement of assistive device such as a brace, cane, or walker]
- [Insert specific condition, e.g., severely limited mobility due to neurological or orthopedic condition]

Based on my clinical assessment, I recommend the following duration for the placard:

Temporary: Valid until [Insert Date]

Permanent: Due to a chronic condition that limits mobility.

If you require any further documentation or have questions regarding this authorization, please contact my office at [Insert Phone Number].

Sincerely,

Signature: _____

Physician/Provider Name: [Insert Name]

Title: [Insert Title, e.g., PT, DPT, MD]

License Number: [Insert License Number]

Facility Name: [Insert Facility Name]

Address: [Insert Facility Address]