

[Physician or Clinic Letterhead]

[Date]

To the Department of Motor Vehicles / Disability Services,

Subject: Medical Authorization for Disabled Parking Placard

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

I am writing to formally certify that the above-named patient is currently under my care for a high-risk pregnancy. Due to her clinical condition, she suffers from significant mobility limitations and physical exhaustion that severely restrict her ability to walk long distances.

Under the criteria established for disabled parking privileges, I am authorizing a **temporary** disabled parking placard for this patient. This accommodation is medically necessary to ensure her safety and the health of the pregnancy by minimizing physical strain and reducing the risk of complications.

The estimated duration of this disability is from [Start Date] until [End Date/Expected Delivery Date plus 6 weeks recovery].

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

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]

[Clinic/Hospital Name]