

MASSACHUSETTS REGISTRY OF MOTOR VEHICLES



Medical Affairs Branch • P.O. Box 55889 • Boston, MA • 02205-5889 • 857-368-8020 *For Hand Deliveries*: 25 Newport Avenue Extension, Quincy, MA

www.massrmv.com

APPLICATION FOR DISABLED PARKING PLACARD/PLATE

THIS SIDE OF THE APPLICATION MUST BE COMPLETED IN THE DISABLED PERSON'S NAME

Disabled person must be a Massachusetts resident. Please note the information required in this application may affect your license status.

- Incomplete applications will not be processed.
- Both disabled person and medical professional signatures are required.
- This application must be submitted to the RMV within thirty (30) days of the healthcare provider's certification.
- Additional documentation may be required.

Signature of disabled person (**REQUIRED**)

REPORT OF CERTAIN MEDICAL CONDITIONS MAY RESULT IN LOSS OF LICENSE

A. Disabled person's	information (please print)		
Last Name	First Nama	Middle	Condor
Last Name	First Name	Middle	Gender
Address	City/Town	Zip Code	
Date of Birth	Social Security Number (SSN)	Height	Telephone Number
Driver's License Number	or Mass I.D. Number		
B. Is this the first tim	e you have submitted an application for	r a disabled parking p	olacard/plate?
Yes No - Please print	your current disabled parking placard or plate nu	umber	
C. I am applying for	the following:		
☐ Placard ☐ Plate ☐ Motorcycle Plate ☐ DV Plate	No fee required for a placard. Only issued to individuals who have a vehicle registered in his/her name. Registration fees apply. Only issued to individuals who have a vehicle registered in his/her name. Registration fees apply. Only issued to individuals who a) have a vehicle registered in their name; b) meet Medical Affairs guidelines; c) provide the DV (Disabled Veteran) Plate letter from the Veteran's Administration stating that the disability is at least 60% service connected.		
D. Important Inform	ation – <i>PLEASE READ</i>		
• For an individual to hav	e your placard, if you are not in the vehicle. e more than one permanent placard. ation to obtain a placard or disabled person plate counterfeit placard.		lse information (Persons can be der Massachusetts law.)
E. Applicant's signat	ure and certification		
 placard or plates that a I certify under the pair my medical status/cor <u>AUTHORIZATION</u> To discuss and release an 	ns and penalties of perjury that all the information dition, is true and correct to the best of my know FO RELEASE MEDICAL RECORDS - I hereby or all medical records pertaining to its content plates, I hereby authorize the Veterans' Admini	on provided in this applicate whedge. y authorize the healthcare with or to representatives	provider completing this form to sof the Registry of Motor Vehicles.

Date

F. TO BE COMPLETED BY HEALTH CARE PROVIDER **CLINICAL** DIAGNOSIS: (Required) DURATION (circle one): Temporary Permanent If temporary, please estimate number of months of disability PLEASE CHECK ALL THAT APPLY: Unable to walk 200 feet without assistance. List necessary ambulatory aids: _____ Legally Blind* (Cert. Of Blindness may substitute for professional certification) (*automatic loss of license) Chronic Lung Disease (check at least one of the following criteria): FEV1 test results _____O² saturation with minimal exertion____ (*automatic loss of license if O^2 saturation $\leq 88\%$) Use of Portable Oxygen? Yes _____ No Note: Asthma is not in and of itself a qualifying condition. Please describe degree and frequency of impairment (pulmonary test results required.) Cardiovascular Disease AHA Functional Classification (circle one): II Ш IV*(*automatic loss of license) Arthritis (please state type, severity, and location) Loss of limb or permanent loss of use of a limb HEALTHCARE PROVIDER MUST CHECK ONE: In my professional opinion and to a reasonable degree of medical certainty: The above condition, or any other medical condition of which I am aware, WILL NOT IMPAIR the safe operation of a motor vehicle. The person applying for this permit is **NOT** medically qualified to operate a motor vehicle safely. The medical condition as stated above is of such severity as to require a *COMPETENCY ROAD TEST*. G. Doctor's Signature and Certification Medical Professional's daytime phone number Medical Professional's Last Name First Name Middle Name Medical Professional's Address City State Zip I certify that I am a Medical Professional Chiropractor Registered Nurse Physician's Assistant Optometrist (legal blindness only) Podiatrist and certify under the pains and penalty of perjury that the information I have provided is true and correct. Professional's Medical License Number (**REQUIRED**) Medical Professional's Signature (**REQUIRED**) Date

-2- T20060-1112