MASSACHUSETTS REGISTRY OF MOTOR VEHICLES

Medical Affairs Branch • P.O. Box 55889 • Boston, MA • 02205-5889 • (617) 351-9222
For Hand Deliveries: 25 Newport Avenue Extension, Quincy, MA
www.mass.gov/rmv

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.

REPORT OF CERTAIN MEDICAL CONDITIONS MAY RESULT IN LOSS OF LICENSE

A. Disabled person's information (please print)

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 time you have submitted an application for a disabled parking placard/plate?

☐ **Yes**
☐ **No -** Please print your current disabled parking placard or plate number_____

C. I am applying for the following:

☐ **Placard**	No fee required for a placard.
☐ **Plate**	Only issued to individuals who have a vehicle registered in his/her name. Registration fees apply.
☐ **Motorcycle Plate**	Only issued to individuals who have a vehicle registered in his/her name. Registration fees apply.
☐ **DV Plate**	Only issued to individuals who a) have a vehicle registered in their name; b) meet Medical Affairs guidelines; c) provide the DV Plate letter from the Veteran's Administration stating that the disability is at least 60% service connected.

D. Important Information – *PLEASE READ*

It is illegal . . .

- To allow someone to use your placard, if you are not in the vehicle.
- For an individual to have more than one permanent placard.
- To provide false information to obtain a placard or disabled person plates.
- To possess or display a counterfeit placard.
- To forge a doctor's signature.
- To provide false information (Persons can be prosecuted under Massachusetts law.)
- To alter a placard.

E. Applicant's signature and certification

- I have read the "Important Information" in section "D" and fully understand and take responsibility for the use of the disabled placard or plates that are issued to me.
- I certify under the pains and penalties of perjury that all the information provided in this application, including the representation of my medical status/condition, is true and correct to the best of my knowledge.
- AUTHORIZATION TO RELEASE MEDICAL RECORDS - I hereby authorize the healthcare provider completing this form to discuss and release any or all medical records pertaining to its content with or to representatives of the Registry of Motor Vehicles.

_____ _____

Signature of disabled person (**REQUIRED**) 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 _____ O^2 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): I II III 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 Last Name First Name Middle Name Medical Professional's daytime phone number

_____
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.

_____ | | | | | | | | | | | | |
Medical Professional's Signature (**REQUIRED**) Date Professional's Medical License Number (**REQUIRED**)