STATE OF RHODE ISLAND -- DIVISION OF MOTOR VEHICLES
Disability Section
600 New London Avenue ,Cranston, RI 02920-3024
www.dmv.ri.gov

NEW/RENEWAL DISABILITY PARKING PLACARD APPLICATION

Applicant must be a Rhode Island resident only. This application must be submitted within thirty (30) days of the physician's certification. Please note that the information required in this application may affect your drivers license status. Please allow 4 to 6 weeks for processing. Additional information and documentation may need to be submitted. Incomplete applications will not be processed.

I hereby authorize the physician completing this form to discuss and release any or all of my medical records to representatives of the Division of Motor Vehicles for the purpose of assessing my application.

❑ NEW APPLICATION ❑ RENEWAL: PLACARD NUMBER: _____

Applicant Signature (or Power of Attorney*) Date

*** The Power of Attorney needs to provide a notarized copy of the application reflecting their signature.**

Applicant should provide the following information: (Please Print)

			M❑ F❑	
Last Name	First Name	MI	Gender	Date of Birth

				( )
Residence Address	Apt #	City/Town	Zip Code	Telephone Number

Mailing Address (if different from above)

RI Driver's License Number: ❑ _____ RI State ID Number:❑ #: _____

REVERSE SIDE MUST BE COMPLETED BY YOUR PHYSICIAN

Applicant's Name: _____ Date of Birth: _____

ALL RESPONSES BELOW MUST BE PROVIDED BY YOUR PHYSICIAN

Dear Doctor:
This is an application to allow your patient to display a disability parking placard. The individual's ability to maintain a driver's license will not affect their ability to obtain a placard. If you determine that your patient's medical condition renders them a threat to their own safety and to the safety of others using the roadways, please so indicate below.

Comments: _____

_____

_____

Criteria

A. Cannot walk without the use of a brace, cane, crutch, wheelchair, prosthetic device or another person.
B. Suffer from lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 mm/hg on room air at rest.
C. Needs portable oxygen.
D. Have a cardiac condition to the extent that your functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.
E. Legally blind, visual acuity of 20/200 or worse in the better eye with corrective lenses.

LENGTH OF DISABILITY (check one):

- ❑ Temporary Condition - Expected duration: _____ months.
  (Minimum 2 months; maximum 12 months)
- ❑ Long Term Condition (one to three years duration): _____ years.
- ❑ Permanent Condition (in excess of three years).

PHYSICIAN CERTIFICATION:

By signing this application, I certify that I am currently treating this applicant for a medical condition that meets at least one of the above listed criteria.

_____
Certifying Physician's Name | RI Medical License Number

_____
Address (City/Town/State/Zip Code) | Telephone Number

_____
Medical Specialty | Certifying Physician's Signature

NOTICE:
It is a misdemeanor to knowingly make false statements to a public official and is punishable by fines up to $1,000.00 or up to one year in jail. Rhode Island General Law § 11-18-1.

The Division of Motor Vehicles reserves the right to request further medical documentation to support a physician's certification of eligibility.