



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
 DIVISION OF MOTOR VEHICLES
 Disability Parking Permits Office
 100 Main Street
 Pawtucket, RI 02860-4107
 (401) 462-4368 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. You will need to allow for internal DMV processing time. 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 (or Power of Attorney) Signature

 Date

Applicant should provide the following information: (Please Print)

				M <input type="checkbox"/> F <input type="checkbox"/>
Last Name	First Name	MI	Date Of Birth	Gender

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

 Mailing Address (if different from above)

Employed: Yes ___ No ___ Occupation: _____ RI Driver's License/I.D. #: _____

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

FOR DIVISION OF MOTOR VEHICLE USE ONLY

Approved Date: _____ Parking Permit Number: _____

Disapproved Date: _____ Date Issued: _____

Denial Code: _____ **Notes:** _____

Dear Doctor:

This is an application to allow your patient to display a disability parking placard. This will allow your patient to park in specially designated "handicapped" parking spaces designed to increase access for people with impaired mobility.

The medical criteria you fill out below will enable the DMV to determine if your patient qualifies for the privilege of access to these parking spaces which are limited in number. Should your patient's medical condition raise a concern as to their ability to drive safely, the DMV may request that the patient take a road test, or, if the patient poses an immediate threat, they may need to have their status reviewed.

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 on this application.

Are you the primary physician? _____ How Long? _____ Last Examination Date: _____

***Please check which conditions, if any, accurately describe the person applying for this permit:
(Must be personally verified)***

Ambulatory Range: With Rest: _____ Without Rest: _____

Please state clinical diagnosis and exact nature of impairment:

Has been declared **legally blind: (You must supply copy of certification)**

Applicants in this classification must surrender their driver's license.

If restricted by **lung disease**, what is their FEV-1(<one liter)? ____ Patient's oxygen saturation level:
at rest: _____ PO2 on room air: _____ Uses portable O2? Yes: _____ No: _____

Cardiac Classification according to the standards set by the American Heart Association: _____

Cannot walk without the assistance of another person, prosthetic aid or assistive device.
Please state device used and exact nature of impairment: _____

Paralysis or paresis: Please describe: _____

Has lost one or more limbs or permanently lost the use of one or more limbs which has impaired their ambulation. Please describe: _____

If **Multiple Sclerosis**, Please State Clinical Classification: _____

If any of the above conditions are due to an **arthritic condition**, please state:
Type of arthritic condition: _____
Specific joints and/or limbs affected: _____

If **Rheumatoid Arthritis**, please specify American Rheumatoid Arthritis Functional or Anatomic Classification System Number: _____

Other: (please specify clearly) _____

**You must attach a copy of X-Ray, MRI, or CT Scan Report for any muscular-skeletal condition.
Please do not submit actual X-Ray, CT Scan, or MRI discs or films.**

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 MUST CHECK ONE OF THE FOLLOWING STATEMENTS:

In my professional opinion, and to a reasonable degree of medical certainty:

- The person applying for this permit is medically qualified to operate a motor vehicle safely.
- The person applying for this permit is not medically qualified to operate a motor vehicle safely.

Additional Comments:

PHYSICIAN CERTIFICATION:

I hereby certify that the information I have provided herein is true, accurate, and complete.

Please Print:

Certifying Physician's Name

Medical Registration Number

Address (City/Town/State/Zip Code)

Telephone Number

Certifying Physician's Signature