RHODE ISLAND DIVISION OF MOTOR VEHICLES
100 Main Street
PAWTUCKET, RI 02860
Telephone: (401)588-3008

APPLICATION FOR PARKING PRIVILEGE PLACARD

APPLICANT must be a Rhode Island resident. This application must be submitted within thirty (30) days of the physician's certification. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. Please note the information required in this application may affect your license status. You should allow for internal DMV processing time. Additional documentation may be required.

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

_____

Signature of Applicant Date

Applicant should provide the following information: (Please Print)

_____

Last Name First Name MI Date of Birth

_____ ( ) _____

Address City/Town Zip Code Telephone Number

Currently employed? Yes____ No____ Occupation_____License No:_____

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 No.**_____
☐ **Disapproved** **Date:**_____ **Date Issued:**_____

REASON FOR DENIAL_____

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Dear Doctor:

This is an application to allow your patient to display a parking privilege 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 his or her ability to drive safely, the DMV may request that the patient take a road test, or, if the patient poses an immediate threat, he or she may have their status reviewed.

The individual's ability to maintain a driver's license will not affect his or her ability to obtain a placard. If you determine that your patient's medical condition renders him or her a threat to his or her own safety and to the safety of others using the roadways, please so indicate on this application.

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

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 (please attach copy of certification). Applicants in this classification must surrender their driver's license.

☐ If restricted by lung disease, what is their FEV1 (<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 other assistive device. Please state device used and exact nature of impairment. _____

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

_____

☐ Paralysis or paresis. Please describe._____

☐ Other _____

If any of above conditions are due to an arthritis condition, please state:

Type of Arthritis Condition (classification guidelines)_____

All Joint(s) and/or all Limb(s) Affected (include X-rays reports) _____

Symptoms Experienced (functional status)_____

LENGTH OF DISABILITY (Check One)

☐ Condition is temporary--expected duration (in months)_____(minimum 2 months, maximum 12 months)
☐ Long Term one to three years.
☐ Condition is permanent (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.
Other comments:_____

_____

_____

PHYSICIAN CERTIFICATION

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

_____

Certifying Physician's Name R.I. Registration Number

_____

Address (City/Town/State Zip Code)

_____

Telephone Number Certifying Physician's Signature