



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

**DIVISION OF MOTOR VEHICLES**  
DISABILITY PARKING PLACARDS OFFICE  
600 New London Avenue  
Cranston, RI 02920-3024  
Phone: 401-462-4368  
www.dmv.ri.gov



## NEW/RENEWAL DISABILITY PARKING PLACARD APPLICATION

**Application must be completed in the disabled person's name (not parent, caretaker, guardian or P.O.A.)** Applicant must be a Rhode Island resident. This application must be submitted within thirty (30) days of the physician's certification. Please note that the information provided in this application may affect your driver's license status. Please allow one (1) to two (2) weeks for processing. Additional information and documentation may need to be submitted. Incomplete applications will not be processed.

NEW APPLICATION                       RENEWAL: PLACARD #: \_\_\_\_\_

Applicant must provide the following information (please print):

			M <input type="checkbox"/>	F <input type="checkbox"/>
_____	_____	_____	_____	_____
Last Name	First Name	MI	Gender	Date of Birth
				(    )
_____	_____	_____	_____	_____
Residence Address	Apt #	City/Town	Zip Code	Telephone

\_\_\_\_\_ Mailing Address (if different from Residence Address)

RI Driver's License #:  \_\_\_\_\_ **OR** RI State ID #:  \_\_\_\_\_

*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 solely for the purpose of assessing my application.*

\_\_\_\_\_ **Applicant Signature** (or Power of Attorney\*)

\_\_\_\_\_ **Date**

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

## REVERSE SIDE MUST BE COMPLETED BY YOUR PHYSICIAN

FOR DMV USE ONLY

Date placard was issued: \_\_\_\_\_ Placard # issued: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**NOTE: The physician needs to make sure the application is completed in the disabled person's name (not parent, caretaker, guardian or P.O.A.).**

**ALL RESPONSES BELOW MUST BE PROVIDED BY YOUR PHYSICIAN**

Dear Doctor:

This is an application to allow your patient to utilize 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 or to the safety of others using the roadways, please indicate this below.

Comments:

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**Criteria**

- A. Cannot walk without the use of a brace, cane, crutch, wheelchair, prosthetic device or another person.
- B. Suffers 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. Has 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 two (2) months; maximum twelve (12) months)
- Long Term Condition (one to three years duration): \_\_\_\_\_ years.
- Permanent Condition (in excess of three years).

**PHYSICIAN CERTIFICATION (please print):**

*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 Full Name

\_\_\_\_\_  
RI Medical License Number

\_\_\_\_\_  
Address (City/Town/State/Zip Code)

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Medical Specialty

\_\_\_\_\_  
Certifying Physician's Signature

**NOTE: 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.**