MASSACHUSETTS REGISTRY OF MOTOR VEHICLES
Medical Affairs Branch
P.O. Box 199100
Boston, MA 02119-9100
(617) 351-9222
For Hand Deliveries: 630 Washington St., Boston, 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.

NOTE: Incomplete applications will not be processed. This application must be submitted to the RMV within thirty (30) days of the healthcare provider s certification. You should allow at least thirty (30) days for RMV processing. Additional documentation may be required.

NOTE: REPORT OF CERTAIN MEDICAL CONDITIONS MAY RESULT IN AUTOMATIC LOSS OF LICENSE

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			

Is this the first time you have submitted an application for a disabled parking placard/plate? Yes_____No_____
If applicable, please print your current disabled parking placard or plate number_____

I am applying for the Following:

☐ **Placard** No fee required for a placard (disabled person s photo must be stored before a placard can be issued).

☐ **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 80% service connected.

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 Date

TO BE COMPLETED BY HEALTH CARE PROVIDER

CLINICAL DIAGNOSIS:_____(Required)

DURATION (circle one): Temporary Permanent
If temporary, please state # of months_____

PLEASE CHECK ***ALL*** THAT APPLY:

_____ Unable to walk 200 feet without assistance (clinical diagnosis **MUST** be completed)

_____ Legally Blind* (Cert. Of Blindness may substitute for professional certification) (*automatic loss of license)

_____ Chronic Lung Disease
Please state FEV1 Test results _____O2 saturation with minimal exertion_____
Use of Portable Oxygen? Yes _____ No_____

_____ Cardiovascular Disease
AHA Functional Classification (circle one): I II III IV*
(*automatic loss of license)

_____ Arthritis (please state type, severity, and location)_____
_____

_____ Loss of or permanent loss of use of a limb
Description of functional disability_____
_____

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***.

CERTIFICATION: (Please Print)

_____
Healthcare Provider s Name Title Mass Board of Registration. #

_____
Address

_____
Telephone Number

_____
Healthcare Provider s Signature Date