massDOT
Massachusetts Department of Transportation
Registry of Motor Vehicles

MASSACHUSETTS REGISTRY OF MOTOR VEHICLES

Mail To: Medical Affairs - PO Box 55889 – Boston, MA - 02205-55889 – 857-368-8020 – www.massrmv.com

For Walk-In Service Only: Haymarket Center, 136 Blackstone Street, Boston, MA

APPLICATION FOR DISABLED PARKING PLACARD/PLATE

THIS SIDE OF THE APPLICATION MUST BE COMPLETED IN THE DISABLED PERSON'S NAME

Please note the information required in this application may affect your driver's license status.

- Incomplete applications will not be processed and will be returned.
- **Both disabled person and healthcare provider must sign and date this application. The disabled person's information must be provided in sections A, B, and C. The healthcare provider must complete sections D and E.**
- This application must be submitted to Medical Affairs within **thirty (30) days** of the healthcare provider's certification.
- RMV Service Center locations do not process disability parking applications; dropping off at a service center location may add processing time.
- Additional documentation may be required.

A. Disabled person's information (please print)

Last Name	First Name	Middle	Gender
Residential Address	City/Town		Zip
Mailing Address	City/Town		Zip
Date of Birth	Social Security Number (SSN)	Height	Telephone Number

Mass Driver's License or I.D. Number (if applicable) **Current Placard Number (Expired or Extension of Current Placard)**

B. I am applying for the following

☐ Placard	No fee required for a placard. Disabled person is not required to have a vehicle registered in his/her name.
☐ 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) are primary owner with vehicle registered in their name; b) provide the DV (Disabled Veteran) Plate Letter from the Veteran's Administration listing service connected disabilities and total combined rating; c) have qualifying conditions which meet Medical Affairs guidelines and total at least 60% of the service connected disability.

C. Placard Rules and Acknowledgment

Rules:

- It is illegal to allow someone to use your placard if you are not in the vehicle.
- It is illegal for an individual to have more than one placard (temporary or permanent).
- It is illegal to provide false information (persons can be prosecuted under Massachusetts Law).
- It is illegal to possess or display a counterfeit placard (altered or photocopied).
- It is illegal to forge a healthcare provider's signature.

Acknowledgment:

- I have read the rules listed above.
- I understand misuse of disabled parking may result in high motor vehicle citation fines ($500, first offense), license suspension terms, and the revocation of my disabled parking privileges.
- I certify under the penalty of perjury that all the information provided in this application, including the representation of my medical status/condition, is true and correct to the best of my knowledge.
- 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 RMV.
- For applicants for DV plates, I hereby authorize the Veteran's Administration to release medical information concerning my service connected disability rating(s).

Signature of disabled person (REQUIRED) **Date: (REQUIRED)**

Applicant's Name/Patient's Name: _____ **Last 4 of Social Security #** _____

D. TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

HEALTHCARE PROVIDER MUST CHECK ONE: ***Complete this section regardless of the patient's license status. Failure to complete all sections will result in delayed processing and a request for more information about this patient.***

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

☐ The reported condition ***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 below is of such severity as to require a ***COMPETENCY ROAD TEST***.

This application is completed for individuals who are severely restricted in mobility/ability to walk due to a neurological, orthopedic, arthritic, or other medically debilitating qualifying condition. I acknowledge the RMV grants disabled parking on the basis of necessity and not as a convenience. Disabled parking misuse carries heavy fines and strict license suspension penalties.

CLINICAL DIAGNOSIS: _____ **(REQUIRED)**

DURATION OF PLACARD TO BE ISSUED (circle one): Temporary Permanent

If Temporary, please estimate number of months of disability: _____

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

☐ Unable to walk 200 feet without stopping to rest; list any necessary ambulatory aids: _____
☐ Legally Blind* (Cert. of Blindness may substitute for professional certification). *automatic loss of license
☐ Chronic Lung Disease to such an extent that the applicant's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than 1 liter. Please attach most recent FEV1Test results.
  ☐ Use of portable oxygen

NOTE: Asthma alone is not a qualifying condition. Please describe degree and frequency of impairment (pulmonary function test results are required)

_____

☐ Cardiovascular Disease
  AHA Functional Classification (circle one): I II III IV* (*automatic loss of license)
☐ Loss of Limb or permanent loss of use of a limb (please describe): _____

_____

E. Healthcare Provider Signature and Certification Date- REQUIRED

_____ _____
Provider's Last Name, First Name (please print) Provider's Daytime Phone Number

Provider's Address City State Zip

I am a ☐**Medical Doctor** ☐**Chiropractor** ☐**Registered Nurse** ☐**Physician Assistant** ☐**Osteopath**
☐ **Optometrist (legal blindness only)** ☐**Podiatrist**

I certify under the penalty of perjury that the information I have provided is true and correct to the best of my knowledge.

_____

Provider's Signature (REQUIRED) **Date (REQUIRED)** **Provider's License Number (REQUIRED)**