Request for Replacement Placard

Registry of Motor Vehicles ● Medical Affairs
P.O. Box 55889 ● Boston, MA 02205-5889
Phone: (857) 368-8020 ● Fax: (857) 368-0018

A. Applicant Information

Last Name	First Name	Middle Name	Suffix

Massachusetts License # OR Social Security #	Date of Birth

Residential Address

Street Apt. # City State Zip Code

B. Declaration and Signature

I hereby declare that my Disabled Parking Placard Number (leave blank if not known) _____ has been lost or stolen.

I further declare that the Placard was not confiscated by law enforcement nor was a citation issued for placard abuse to myself or any other person.

The following section is intended to communicate to you the stricter penalties in effect as of July 1, 2018 for those misusing or abusing disability parking privileges under Massachusetts General Law Chapters 90 Sections 2 and 24B.

You must read the following and acknowledge each section by initialing on the line provided.

____ I understand that if I intentionally make a false statement when reporting a disabled parking placard lost or stolen, I shall be subject to a fine of $500 for a first offense and $1,000 for a second or subsequent offense.

_____ I understand that using a placard belonging to a person who is deceased, or using a placard belonging to someone else, is punishable by a $500 fine and 60 day loss of license. Fines and terms of suspension increase with each offense.

____ I understand that, upon receipt of a replacement placard, the original placard number is no longer valid.

____ I understand that continued use of a cancelled placard is against the law and will subject me, or any other user, to hundreds of dollars in fines and penalties including a loss of license for 60 days for a first offense, and 120 days for any subsequent offense.

____ I understand that, should my original placard be found, it is to be returned to the Registry of Motor Vehicles forthwith, or I shall be fined $100 for failure to return a cancelled placard.

____ I understand that, at the Registrar's discretion, I may, at any time, be required to furnish updated medical information relative to my continued eligibility for disabled parking privileges.

I have read the preceding and hereby certify under the penalty of perjury that the information I have provided is true and correct.

Signature: _____ Date:_____