STATE OF RHODE ISLAND

DIVISION OF MOTOR VEHICLES
DISABILITY PARKING PLACARDS OFFICE
600 New London Avenue
Cranston, RI 02920-3024
Phone: 401-462-4368 Fax: 401-462-0829
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 via mail or fax (address or number above) 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 two (2) to four (4) weeks for processing. Additional information and documentation may need to be submitted.
Incomplete applications will not be processed.

☐ NEW APPLICATION ☐ RENEWAL: PLACARD #: _____

NOTE: For motorcycle disability parking permits please include registration information

☐ **(MOTORCYCLE ONLY)** REGISTRATION PLATE #: _____

Applicant must provide the following information (please print):

M ☐ F ☐

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:

_____

_____

_____

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.