CITY OF BOSTON

DISABILITIES COMMISSION

Mayor Michelle Wu

On-Street Accessible Parking Space Program

Medical Documentation Form

This form must be filled out completely by the applicant's Primary Care Physician or a Licensed Specialist. Information must include the Physician's registration number and their signature. Please type or print clearly.

Instructions for Provider: Your patient, named below, is applying for an On-Street Accessible Parking Space (aka Accessible Space) near their home in the City of Boston. To qualify for this program, we need specific information from you about your patient's medical diagnosis and functional limitations. A person must have a physical limitation which prevents them from getting to their home from an on-street parking space farther than one block away. Please read this form in its entirety and complete it accurately to the best of your knowledge only for those patients who you have personally treated and diagnosed with a severely limited ability to walk.

Patient (Applicant) Name: _____ Date of Birth: _____

Clinical Diagnosis (Required): _____ (NO ICD CODES)

Describe Patient SYMPTOMS: _____

Duration of patient's disability (Check One): × Permanent × Temporary (How long? _____)

How does this medical condition affect their ability to walk? _____

How many city blocks can this patient walk? ☐ 1 ☐ 1 ½ ☐ 2 ☐ 3 ☐ Other _____

Have you prescribed any medically necessary mobility devices for this patient? ☐ Yes ☐ No

→If "yes," which devices have you prescribed? ☐Wheelchair ☐Portable oxygen ☐Cane ☐Other_____

How long has this patient been under your care for this condition? _____

How often do you see this patient? ☐ Annually ☐ Monthly ☐ Weekly ☐ Other _____

Does this patient receive medical treatment / therapy outside of their home on a regular basis? ☐ Yes↓ ☐ No

→If "Yes," what treatment / therapy do they receive? _____

→How often do they leave their home for this treatment? ☐ Daily ☐ Weekly ☐ Other _____

Healthcare Provider Certification and Signature (Required)

I am: ☐ Medical Doctor ☐ Chiropractor ☐ Registered Nurse ☐ Physician Assistant ☐ Other _____

Provider's Name (printed clearly): _____

MA Board of Registration Number: _____

Phone Number: _____

Name of Hospital/Clinic of Medical Practice: _____

Address of Medical Practice: _____

I hereby certify that the above information is true and accurate under the pains and penalties of perjury.

_____ _____

Provider Signature Date