CITY OF REVERE

Application for Residential 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 Physician: Your patient, named above, is applying for a Residential Accessible Parking Space (APS space) 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.

Date: _____

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

Doctor's Relationship to Patient: PCP ☐ **Specialist** ☐ → **Other** ☐ → *Specialty/Other:* _____
Describe Patient DIAGNOSIS:

Is this a permanent condition? **Yes** ☐ **No** ☐↓

→If this condition is temporary, how long do you expect it to last?

Describe Patient SYMPTOMS:

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** ☐ → _____

****** A copy of your prescriptions for all mobility devices MUST be enclosed with application ******

Please check off any of the following medical conditions that accurately describe your patient's disability:

☐ **Lung Disease: Yes** ☐ **No** ☐ → **Does this require the use of portable oxygen? Yes** ☐ **No** ☐

Explain: _____

_____

_____

☐ **Class III or Class IV Cardiac Condition, according to the American Heart Association Explain:** _____

_____

_____

☐ **Arthritis: Type of Arthritis**_____ **Joints Affected:** _____

Explain: _____

_____

☐ **Other mobility impairment that requires the use of a medically necessary mobility device (wheelchair, scooter, prosthesis, walker or cane). A prescription for this mobility device must be included.**

Explain: _____

_____

_____

Physician's Name (printed clearly) _____

Name of Hospital, Clinic of Medical Practice _____

Address of Medical Practice _____

Phone Number: _____ **Email:** _____

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

_____ _____

Physician Signature **MA Board of Registration Number**