

**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:**

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Is this a permanent condition? Yes  No ↓

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

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**Describe Patient SYMPTOMS:**

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

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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