CS

Disability Parking Scheme Application for Individuals

The 'applicant' is the person with the disability.
To be completed by the applicant or the applicant's agent. Please use BLOCK letters.

1. Title (please circle)

MR	MRS	MISS	MS	MASTER

2. Given/Christian names

3. Surname

Date of birth

4. Residential address

Telephone

5. Postal Address – if different from above

6. Is the permit for a:

A. Driver/ Passenger ☐ B. Passenger only ☐ D. Temporary permit ☐

7. If driver/passenger please provide

Drivers licence number

Expiry date

8. What is your disability?

9. What appliances do you use as an aid?

Declaration by applicant

I make this declaration in the firm belief that all the information provided on this form is, to the best of my knowledge, true and correct and I am aware that false declarations may be punishable by law.

I will comply with the conditions of use for the permit.

If my circumstances change in any way likely to affect my eligibility for the permit, I agree to notify the issuing authority within 14 days. I further agree that the permit remains the property of the issuing council and will be returned within seven (7) days of notification of such return being required.

Applicant's signature (or applicant's agent signature)

Date

Please see overleaf for medical practitioner, specialist medical practitioner or clinical psychologist statement.

OFFICE USE ONLY

Completed By:

Issue Date	**Code & Category**	**Permit Number**	**Expiry Date**

Disability Parking Scheme
Application for Individuals

Statement for completion by a medical practitioner, specialist medical practitioner or clinical psychologist

PLEASE NOTE: The information on this form will be used by Council staff to determine the eligibility of your patient for a disabled person's parking permit. A permit will not be issued unless all details on the application are completed.

10. What is your patient's disability?

11. Does your patient's disability require him/her to continually use an appliance for support to aid his/her mobility?

12. Does your patient require additional space to access his/her vehicle due to the disability?

13. Does the use of the aid cause your patient the need to use this space?

14. What appliance does your patient use as an aid?

15. Is the significant disability permanent?
If **NO** go to question 16. If **YES** go to question 17. **YES** ☐ **NO** ☐

16. Is the significant disability likely to be less than six months? **YES** ☐ **NO** ☐

17. Does your patient's disability result in extreme danger to themselves or others in a public place without the continuous attendance of a care giver? **YES** ☐ **NO** ☐

18. Does your patient's disability affect their capacity to walk distances such that they require rest breaks? **YES** ☐ **NO** ☐

19. Does the applicant have either an acute or chronic illness in which minimal walking may endanger his/her health acutely or in the long term? **YES** ☐ **NO** ☐
If 'YES' please explain

20. Is the mobility aid consistent with the applicant's disability?

21. Additional supporting information known to you.

Declaration
I make this declaration in the firm belief that all the information provided on this form is, to the best of my knowledge, true and correct and I am aware that false declarations may be punishable by law.

Signature of medical practitioner / specialist / clinical psychologist

Date

Name of medical practitioner / specialist / clinical psychologist

Qualifications

Address

Telephone number

An appropriate charge for completion of this application and any necessary examination is to be borne by the applicant.