# DISABLED PERSONS PARKING SCHEME APPLICATION

The Applicant is the person with the disability
To be completed by the Applicant or the Applicant's Agent
Use BLOCK letters only

| Office Use Only | Date |
|---|---|
| No._____ | ____/____/____ |
| Expiry Date | ____/____/____ |

1. Surname

2. Given/Christian Names

Date of Birth

3. Residential Address

Telephone Numbers

Postal Address (if different from above)

4. Is the label for a: Driver/Passenger ☐ Passenger only ☐ Temporary permit ☐

**Question 5 should be completed by the Driver/Passenger only.**

5. **Driver Details**

Driver's License No.

Expiry Date

6. What is your disability?

7. What appliance do you use as an aid?

8. **Declaration by Applicant**

I make this declaration in the firm belief that all the information provided on this form is, to the best of knowledge, true and correct and I am aware that false declarations may be punishable by law. I will fully 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 fourteen (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 be being required. The Applicant's agent may sign and take full legal responsibility on the Applicant's behalf.

Applicant's signature (or Applicant's Agent)

Date

**STATEMENT FOR COMPLETION BY A MEDICAL PRACTITIONER/ SPECIALIST MEDICAL PRACTITIONER/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 Persons' Parking Permit.** A permit will not be issued unless all the details on the application are completed.

**OFFICE USE ONLY – COUNCIL DATE STAMP**

9. What is your patient's disability?

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

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

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

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

14. Is the significant disability permanent? YES NO
If NO go to question 15. If YES go to question 16.

15. Is the significant disability likely to last lest than six months? YES NO

16. Does your patient's disability result in extreme danger to themselves or others in a public place without the continuous attendance of a caregiver? YES NO

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

18. 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?

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

20. 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.