Disabled Persons' Parking Scheme - Application

Office Use Only
Received:
Permit:
Date Issued: / /
Expiry Date: / /
Reissue? Y / N Blue / Green

Part A – must be completed by the Applicant (the person with the disability or the Applicant's Agent
Part B – must be completed by a Medical Practitioner/Specialist Medical Practitioner/Clinical Psychologist

Please PRINT with BLOCK LETTERS.
PART A FOR COMPLETION BY APPLICANT

1. Surname Title (please circle)

	Mr / Mrs / Ms / Miss

2. Given/Christian Names **Date of Birth** **Telephone Number**

3. Address

4. Is the label for a:-

Driver/Passenger ☐ Passenger Only ☐ Temporary Permit ☐

Question 5 should be completed by Driver/Passenger only.

5. Driver Details

Driver's Licence 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 my 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 97) days of notification of such return 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**

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

NOTE: THIS AUTHORITY IS TO BE GIVEN TO THE MEDICAL PRACTITIONER/SPECIALIST MEDICAL PRACTITIONER/CLINICAL PSYCHOLOGIST, TO BE FILED WITH THE PATIENT'S RECORDS

Authorisation for medical Practitioner/Specialist Medical Practitioner/Clinical Psychologist to complete this application form.

Insert Name of Practitioner

Address

I hereby authorise you to complete my application for a Disabled Person's Parking Permit for the Alpine Shire Council. I further authorise you to provide additional information or opinion relevant to the consideration or any reconsideration of my application as may be reasonably requested by the authorised Council Officer.

Applicant's signature (or Applicant's Agent) Date

Name in BLOCK letters

PART B – 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 details on the application are completed.

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?

	YES	NO
14. Is the significant disability permanent? If NO go to question 15. If YES go to question 16.	☐	☐
15. Is the significant disability likely to last less than six months?	☐	☐
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?	☐	☐
17. Does your patient's disability affect their capacity to walk distances such that they require rest breaks?	☐	☐
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? If 'yes'' please explain?	☐	☐
	YES	**NO**
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 No.**