

Disabled Permit Application Form

This form has two parts to be completed. Please use **BLOCK LETTERS**

- 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 as nominated by the applicant.

Part A

Office Use Only	Date Issued / /
Permit No :	Code:
Category :	Expiry Date / /
Issued by:	

1. **Surname**

2. **Given Name**

Date of Birth

3. **Address**

Telephone Number

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 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 anyway 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 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

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 and to forward it to the

CITY OF BOROONDARA

I further authorise you to provide additional medical 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

Date

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?

14. Is the significant disability permanent?
If NO go to question 15. If YES go to question 16. Yes No
15. Is the significant disability likely to last less 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 rest breaks? Yes No
18. Does the disability affect their capacity to walk to such an extent that it may become severely injurious (as opposed to inconvenient) to their health?
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 are punishable by law.

Signature of Medical Practitioner / Specialist / Clinical Psychologist

Date

Name of Medical Practitioner / Specialist / Clinical Psychologist

Qualifications

Address

Telephone Number

Postal address:

City of Boroondara
Local Laws Department
Private Bag 1
Camberwell VIC 3124

Fax to:

City of Boroondara
Local Laws Department
(03) 9278 4466

Privacy Statement:

The personal information requested on this form is being collected by council for the purpose of issuing an individual disabled persons parking permit, in accordance with the Road Safety (Road Rules) Regulations (Vic) 1999 and associated code. The personal information will be used solely by council for that primary purpose or directly related purposes. Council may disclose this information to other municipal councils for the purpose of confirming the existence of a valid disabled persons parking permit issued by the City of Boroondara. If this information is not collected council may not issue a disabled persons parking permit. The applicant understands that the personal information provided is for the purpose of issuing a disabled persons parking permit and that he or she may apply to council for access to and/or amendment of the information. Requests for access and or correction should be made to council's privacy officer.