DISABLED PERSONS PARKING PERMIT APPLICATION

MOORABOOL SHIRE COUNCIL

Fee $8.50

The Applicant is the person with the disability.

To be completed by Applicant or Applicant's Agent. USE BLOCK LETTERS.

Office Use Only	Date
Category	/ /
Permit No -	
Expiry Date	/ /

New ☐ Renewal ☐ Replacement ☐
(Please attach explanation)

1. Title:	Surname:	Given/First Names:
2. Date of Birth: ___/___/_____	3. Telephone 1:	Telephone 2:
4. Current Residential Address: Postcode:		

5. Is the permit for a:

Driver/Passenger	☐	5. **If yes** Licence No:	Expiry Date:
Passenger only	☐		
Temporary Permit	☐		

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 (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.

I ..... (please print) understand that the information provided above will be used in accordance with relevant legislation and declare that this information is correct to the best of my knowledge.

Applicants signature (or Applicant's Agent) Date

Please note: The information you provide will be held securely and your privacy respected. Your details will not be provided to any other organisation, nor used for any other purpose.

FOR COMPLETION BY A MEDICAL PRACTITIONER/SPECIALIST 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 Persons' Parking Permit. Please complete in full.

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 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? 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.