



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.

1. Surname Mr Mrs M/s Miss

2. Given Names

Date of Birth

3. Address Postcode

<input type="text"/>	<input type="text"/>
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Telephone Numbers

Postal Address (if different from above) Postcode

<input type="text"/>	<input type="text"/>
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Other phone Numbers

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

Question 5 should be completed by Driver only

5. Driver Details

Driver's Licence No. Expiry Date

<input type="text"/>	<input type="text"/>
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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.

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 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 |
| | <input type="checkbox"/> | <input type="checkbox"/> |
15. Is the significant disability likely to last less than six months?
- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| | <input type="checkbox"/> | <input type="checkbox"/> |
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 |
| | <input type="checkbox"/> | <input type="checkbox"/> |
17. Does your patient's disability affect their capacity to walk distances such that they require rest breaks?
- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| | <input type="checkbox"/> | <input type="checkbox"/> |
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
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
- 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.

PRIVACY STATEMENT

Greater Shepparton City Council manages personal and health information (“information”) in accordance with its Privacy Policy, the *Privacy and Data Protection Act 2014* (Vic) and *Health Records Act 2001* (Vic). Information is collected to communicate with you and process the disabled persons parking scheme application. It is disclosed to regulatory services employees and may be disclosed to other areas of Council for this purpose. If you do not provide the requested information we may be unable to process the application. To gain access to or update your information please contact Council on 5832 9700.