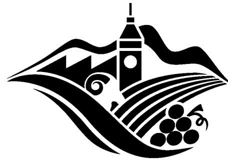

Ararat Rural City

Disabled Persons Parking Scheme - Application

***** The Applicant is the person with the disability.***
***** The Applicant must supply a copy of identification (eg. driver's licence or pension card)***
> Applicant or Applicant's agent to complete Page 1.
(**USE BLOCK LETTERS)
> Medical Practitioner to complete Page 2.
> The Applicant must sign the attached Medical Practitioner Authorisation Form.

A $20 fee applies to all new and existing application.

Office Use Only ****
*Issue Date: / /
*Expiry Date : / /
* **BLUE** ☐ **GREEN** ☐ **PERMIT NO.**
*Processed by:
*Issued by:
$20 Fee Receipt No:

IF A REPLACEMENT PERMIT IS REQUIRED THE $20 APPLICATION FEE WILL APPLY

1. Surname

Mr/Mrs/Ms/Miss

2. Given/Christian Names	Date of Birth

3. Address	Telephone Numbers

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

Question 5 should be completed by Driver/Passenger only

5. Driver's Licence No.	Expiry Date

6. What is your disability?

7. Do you use an aid? Yes ☐ No ☐

7a. If Yes. 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 declaration 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? Is the disability ambulatory? Yes ☐ No ☐

(Brief Explanation)

10. Does your patient's disability require him/her to continually use an appliance for support to aid his/her mobility? Yes ☐ No ☐

11. If "Yes". What appliance does your patient use as an aid?

12. Does your patient require additional space to access his/her vehicle due to the disability? If "Yes", why? Yes ☐ No ☐

13. Does use of the aid cause your patient to need to use this space? Yes ☐ No ☐
(* The aid must be a complex walking aid with more than one contact point with the ground.)

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 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 used consistent with the applicant's disability? Yes ☐ No ☐

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.

THIS FORM MUST BE IMPRINTED WITH THE CLINIC OR MED. CENTRE STAMP

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

Medical Practitioner/Specialist Medical Practitioner/Clinical Psychologist

AUTHORISATION FORM

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 the application form.

Insert name of Practitioner

Address

I hereby authorise you to complete my application for a Disabled Persons' Parking Permit and if required forward it to the Ararat Rural City Council, PO Box 246, Ararat 3377.

I further authorise you to provide additional medical information or opinion relevant to the consideration 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

MEDICAL PRACTITIONER TO DETACH AND RETAIN FOR PATIENT RECORD.