DISABLED PERSONS PARKING SCHEME APPLICATION

BULOKE SHIRE COUNCIL

Office Use Only
Records Department

File No: CS/16/34

Document No:

Please forward this completed form to the HACC department for processing

SECTION 1 - APPLICANT DETAILS - *The applicant is the person with the disability*

Title

Given/Christian Names

Family Name

Address

Home Phone Number

Mobile Phone Number

Date of Birth

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

Question 2 should be completed by Driver/Passenger only.

2. Driver's Licence Number

Expiry Date

3. What is your disability?

4. What appliance do you use as an aid?

SECTION 2 - APPLICANT 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. I will fully comply with the "Conditions of Use" for the Permit. If my circumstances change in any way, and are likely to affect my eligibility for the permit, I agree to notify the issuing authority within (14) days. I further agree that the permit remains the property of the issuing council and will be returned within (7) days of notification of such return being required. The Applicant's agent may sign and take full legal responsibility on the Applicants behalf.

Name _____ Signature _____ Date _____

Privacy Statement

We respect your privacy. We will not sell or give away your personal information,unless required by law. Occasionally, we may use your details for our own research purposes or to let you know about other council information. If you want to see your personal data, modify your details, or if you receive information from us you do not want in the future, please contact: 1300 520 520.

SECTION 3 - 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 Person's Parking Permit. A permit will not be issued unless all details on the application are completed.*

1. What is your patient's disability?

_____

2. Does your patient's disability require him/her to continually use an appliance for support to aid his/her mobility?

_____

3. Does your patient require additional space to access his/her vehicle due to the disability?

_____

4. Does the use of an aid cause your patient the need to use this space?

_____

5. What appliance does your patient use as an aid?

_____

6. Is the significant disability permanent? ☐ Yes ☐ No
   If yes go to question 8
7. Is the significant disability likely to last less than six months? ☐ Yes ☐ No
8. 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
9. Does your patient's disability affect their capacity to walk distances such that they need rest breaks? ☐ Yes ☐ No
10. Does your patient have either an acute or chronic illness in which minimal walking may endanger his/her health acutely or in the long term? ☐ Yes ☐ No

If "yes" please explain? _____

11. Additional supporting information known to you.

_____

SECTION 4 - DECLARATION OF MEDICAL PRACTITIONER / SPECIALIST MEDICAL PRACTITIONER / CLINICAL PSYCHOLOGIST

I make this declaration in the firm belief that all the information provided on this form is, to the best of my knowlegde, true and correct and I am aware that false declarations may be punishable by law.

Name _____ Signature _____

Address _____

Qualifications _____ Phone No _____ Date _____

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

Office Use Only: Issued By: _____ Date Issued: _____

Permit Number: _____ Expiry Date: _____