Application

Disability Parking Permit Scheme

CORANGAMITE SHIRE

PLEASE ENCLOSE $11.00 TO COVER ADMINISTRATION COSTS
(Please allow at least one week from receipt of application for processing.)

Office Use Only: No.:	Date:	Expiry Date:

PLEASE NOTE: A permit will not be issued unless all details on the application are completed. The applicant is the person with the disability. Please check all details are correctUSE BLOCK LETTERS ONLY.

Applicant: _____

Address (must be a resident of Corangamite Shire) _____

_____

Date of Birth: _____ Telephone No.:_____

1 Is the permit for a: Driver/Passenger Passenger Only Temporary Permit

2 If Driver/Passenger, please complete details below with applicant's licence details:

Driver's Licence No.:_____ Licence Expiry Date: _____

3 What is your disability?

_____

_____

4 What appliance/s do you use as an aid?

_____

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. I will fully comply with the "Conditions of Use" for a 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: _____

PLEASE ENSURE BEFORE RETURNING THIS FORM TO US, THAT THE BACK IS COMPLETED IN FULL BY YOUR DOCTOR.

Corangamite Shire, 181 Manifold Street, Camperdown, 3260
Ph. 03 5593 7100, Fax. 03 5593 2695, Email. shire@corangamite.vic.gov.au
www.corangamite.vic.gov.au

STATEMENT FOR COMPLETION BY A MEDICAL PRACTITIONER / SPECIALIST / 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.

5 What is your patient's disability?

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

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

8 Does the use of the aid cause your patient the need to use this space?

9 What appliance does your patient use as an aid?

10 Is the significant disability permanent? YES
If YES go to Q11. NO

10a Is the significant disability likely to last less than six months? YES
NO

11 Does your patient's disability result in extreme danger to themselves or others in a public place without the continuous attendance of caregiver? YES
NO

12 Does your patient's disability affect their capacity to walk distances such that they require rest breaks? YES
NO

13 Does the applicant have either an acute/chronic illness in which minimal walking may endanger his/her health acutely or in the long term? If YES, then please state why?

14 Is the mobility aid consistent with the applicant's disability?

15 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.

Signature of Medical Practitioner / Specialist / Clinical Psychologist:	
Name of Medical Practitioner / Specialist / Clinical Psychologist:	
Qualification:	Date
Address:	Telephone No: