# Disabled Persons' Parking Permit Application

Maribyrnong CITY COUNCIL

* The Applicant is the person with the disability
* The Applicant must supply a copy of identification showing their current address (Eg driver's licence or pension card)
* This form is to be completed by the Applicant or the Applicant's Agent
* The information on this form will be used by Council staff to determine the eligibility of the applicant for a Disabled Persons' Parking Permit
* A permit will not be issued unless all details on the application are provided

Mr ☐ Mrs ☐ Ms ☐ Miss ☐

1. Surname

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2. First Name | Date of Birth

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|---|---|
| | |

3. Address | Telephone Numbers

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|---|---|
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4. Is the permit for a: Driver/Passenger ☐ Passenger Only ☐ Temporary Permit ☐

5. Driver's Licence No. | Expiry Date

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6. What is your disability?

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7. What appliance do you use as an aid?

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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 a 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

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## QUESTIONS 9 – 21 AND THE DECLARATION OVERLEAF TO BE COMPLETED BY A MEDICAL PRACTITIONER / SPECIALIST MEDICAL PRACTITIONER / CLINICAL PSYCHOLOGIST

9. What is your patient's disability?

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

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

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

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

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**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 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 consistent with the applicant's disability?**

**20.** **Additional supporting information known to you.**

**21.** **Additional information based on the applicant's disability relating to their ability to drive.**

## Medical Practitioner 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** |
|---|---|
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**Authorisation for Medical Practitioner to complete the application form. A copy of this authorisation is to be given to them to be filed with the patient's records.**

**Name of Practitioner**

**Address**

I hereby authorise you to complete my application for a Disabled Persons' Parking Permit.

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.

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

| **Applicant's signature ( or Applicant's Agent )** | **Date** |
|---|---|
| | |

| **Name** | **Date** |
|---|---|
| | |

**How to Apply:**

**Email:** email@maribyrnong.vic.gov.au

**Post:** Maribyrnong City Council, P.O. Box 58, Footscray Vic 3011

**In person**: Council Offices, Cnr Napier & Hyde Streets, Footscray Vic 3011
Office Hours 8:30am – 5pm Monday to Friday