Disabled Persons Parking Scheme Application

Colac Otway SHIRE

DISABLED PERMIT FEE OF $10 TO ACCOMPANY APPLICATION

Permit will not be issued unless payment is made.

Office Use Only	
Date	/ /
Category	
No.	
Expiry	/ /

Please tick the correct box. New: ☐ Renewal: ☐

1. **Title** 2. **Surname**

Mr, Mrs, Miss, Ms, other	

3.**Given/Christian Names** 4.**Date of Birth**

5. **Address** 6.**Telephone Number**

7.**This is a Label for a:**

- ☐ Driver (**You must complete section 8**)
- ☐ Passenger only (**skip to section 9**)
- ☐ Temporary Permit (**skip to section 9**)

8.**Only to be completed for Driver labels**

Licence No. _____ Expiry date / /

9. **What is your disability?**

10. **What appliance (if any) do you use as an aid?**

11.**Declaration by applicant**

I make this declaration in the firm belief that 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 from Colac Otway Shire requesting return of this permit. The applicant's agent may sign and take full legal responsibility on the applicant's behalf. Council respects all personal and confidential information you give and will do everything possible to protect information from unauthorised access, loss or misuse. Information collected from you is required for the delivery of Council Services in accordance with Council's powers, function and purposes under the *Local Government Act 1989* and other relevant legislation. It may also be used by Council to conduct research and customer satisfaction surveys so that we may better understand community needs and can improve service delivery.

I …… (Please print) understand that the information provided above will be used in accordance with relevant legislation and declare that this information is true and correct to the best of my knowledge.

Applicant's Signature (or Applicant's Agent) **Date**

STATEMENT BY MEDICAL PRACTITIONER

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 the details on the application are completed**.

12. **What is your patient's disability?**

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

14. **What appliance does your patient use as an aid?**

15. **Does the use of the appliance or your patients disability require additional space for your patient to access a vehicle?** ☐ Yes ☐ No

16. **Is the mobility aid consistent with the applicant's disability?** ☐ Yes ☐ No

17. **Is the mobility aid considered a complex walking aid?** ☐ Yes ☐ No
***** A complex walking aid is defined as an aid which has more than one contact point with the ground. Walking sticks (even multi-pronged) are NOT complex walking aids.

18. **Duration of the significant disability?**
☐ Permanent ☐ More than 12 months (specify)
☐ 6 to 12 months ☐ 3 to 6 months
☐ 0 to 3 months

19. **How far can the applicant walk without a rest break?**

20. **Does your patient's disability require the continuous attendance of a caregiver?** ☐ Yes ☐ No

21. **Does the disability affect their capacity to walk to such an extent that it may become severely injurious (as opposed to inconvenient) to their health? (if Yes then please provide a detailed explanation)** ☐ Yes ☐ No
* If applicant is a falls risk, please provide further details.

22. **Any additional information which may assist with assessment (see page 3 for additional space)**

22.- **Continued**

23**. Declaration by the Medical Practitioner / Specialist Medical Practitioner / Clinical Psychologist.**
I make this declaration in the 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/ Psychologist		Date	
Name of Medical Practitioner/Specialist/ Psychologist		Qualifications	
Address			
Telephone Number			

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

Disabled Person's Parking Permit

NOTE: This authority is given to the Medical Practitioner / Specialist Medical Practitioner / Clinical Psychologist.

To be filed with the patient's records.

Authorisation for the 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 Person's Parking Permit and to forward it to Colac Otway Shire.

I further authorise you to provide additional medical information or opinion relevant to the consideration or any reconsideration of my application as may be reasonably requested by an authorised Council officer.

Applicant's Signature (or Applicant's Agent) Date

Name in Block Letters Date

Please return completed form to:
Colac Otway Shire
PO Box 283
Colac VIC 3250