



APPLICATION FOR A DISABLED PERSON'S PARKING PERMIT

The purpose of the Disabled Persons Parking Scheme is to provide equality of opportunity, to people with a disability, in the accessing of facilities and services. Disabled Person's Parking Permits may be issued only for a medical necessity that severely affects mobility. The Scheme is administered by individual municipal Councils in accordance with the Vicroads guidelines. The following check list indicates the types of disabilities that are eligible for a permit. If you do not have one of these disabilities then you will not obtain a permit.

- Permanently use a wheelchair, motorised scooter, or similar assistive device.
- Inability to walk without the use of or assistance from a brace, cane, crutch, prosthetic device, fixed or mobile walking frames, or other assistive device, or without the assistance of another person.
- Use an assistive device that prevents access to a vehicle in a standard sized parking bay.
- Have an arthritic, neurological, psychological, cardiac or orthopaedic condition that exhausts their physical capacity to walk 60 metres.
- Use of an oxygen unit.
- Present an extreme risk to the applicant or others is likely without the constant attendance of a caregiver.

This form should be filled in prior to forwarding it to your doctor or occupational therapist. The completion of this form may be subject to cost by your doctor or occupational therapist that may not be recoverable.

Section 1

To be completed by the Applicant or the Applicant's Agent.

Name _____

Address _____

Postal Address if different to above _____

Phone numbers (Home) _____ (Work) _____

Date of Birth _____ Are you: Male Female
(Delete which is not applicable)

Type of permit required (please tick ✓)

Driver or Passenger Passenger only Temporary

Drivers Licence No. _____ Expiry Date _____

Are there any restrictions on this licence? Yes No
(Delete which is not applicable)

Section 2

For the Applicant, or the Applicant's Agent to complete.

Please complete **ALL QUESTIONS** in this section by circling

Yes or **No**

Use of Assistive Devices

- Q1. The need to permanently use a wheelchair
- Q2. The need to permanently use a wheelchair type device

Yes	No
Yes	No

Inability to walk without the use of or assistance from:

- Q3. A brace
- Q4. A cane
- Q5. A Crutch
- Q6. A prosthetic device
- Q7. An assistive device similar to a brace, cane, crutch or prosthetic device
- Q8. Another person
- Q9. An assistive device as listed in Questions 3 to 8 that prevents access to a vehicle in a standard sized parking bay

Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No

Physical capacity to walk 60 metres:

- Q10. Exhausted after walking 60 metres
- Q11. Exhausted after walking 60 metres and the walking causes further injury

Yes	No
Yes	No

Reason for reduction in physical capacity to walk 60 metres:

- Q12. Due to arthritic condition
- Q13. Due to neurological condition
- Q14. Due to psychological condition
- Q15. Due to orthopaedic condition
- Q16. Due to cardiac condition

Yes	No
Yes	No
Yes	No
Yes	No
Yes	No

Breathing difficulties

- Q17. Requires the use of a hand held style oxygen unit
- Q18. Requires the use of portable trolley style oxygen unit

Yes	No
Yes	No

Psychological Conditions

- Q19. Where extreme risk to the person or others is likely without the
Constant attendance of a caregiver

Yes	No
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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 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.
- I also understand that the issuing council has the right to advise Vic Roads upon the issue of the Disabled Person’s Parking Permit to me.

The Applicant’s agent may sign and take full legal responsibility on the Applicant’s behalf.

Applicant’s signature (or Applicant’s Agent)

Date

**Section 3
For the Medical Practitioner to complete.**

Use of Assistive Devices:

Is the applicant’s response consistent with their level of disability?

Yes	No
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Inability to walk without the use of, or assistance from:

Is the applicant’s response consistent with their level of disability?

Yes	No
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Physical capacity to walk 60 metres:

Is the applicant’s response consistent with their level of disability?

Yes	No
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Reason for reduction in physical capacity to walk 60 metres:

Is the applicant’s response consistent with their level of disability?

Yes	No
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Breathing difficulties:

Is the applicant’s response consistent with their level of disability?

Yes	No
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Is the applicant restricted in physical capacity to walk by lung disease to the extent that the person’s forced (respiratory) expiratory volume for 1 second, when measured by spirometry, is less than 1 litre, or the person’s arterial oxygen is less than 60 mm/hg on room air at rest

Yes	No
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Psychological Conditions:

Is the applicant’s response consistent with their level of disability?

Yes	No
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Section 4

Supporting Comments for the Medical Practitioner to complete (if necessary).

Use of Assistive Devices

Inability to walk without the use of Assistive Devices

Physical capacity to walk 60 metres

Reason for reduction in physical capacity to walk 60 metres

Breathing difficulties

Psychological Conditions

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.

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.

Name of
Medical Practitioner/
Specialist/ Psychologist/
Occupational Therapist
(BLOCK LETTERS)

Qualifications

Address

Telephone No

Signature of
Medical Practitioner/
Specialist/ Psychologist/
Occupational Therapist.

Date