Mildura Rural City Council

OFFICE USE	
	DATE ISSUED:
	EXPIRY DATE:
	BLUE PERMIT NO:
	GREEN PERMIT NO:
	NEW / RENEWAL
	FILE NO: 11/05/01

Disabled Persons Parking Scheme
Application

Part A: to be completed by the applicant or the applicant's agent

Please complete this form using BLOCK letters.

Full Name: | Date of birth:

Residential address:

Postal address:

Phone Number:

Is the label for a: ☐ Driver (A) ☐ Passenger (B), or is it a ☐ Temporary Permit

If you answered **Driver (A)**, please answer this additional question:

Drivers licence no: | Expiry date:

What is your disability?

What appliance do you use as an aid?

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 be 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

Part B: to be completed by a medical practitioner, specialist medical practitioner or 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 Persons' Parking Permit. A permit will not be issued unless ALL details on the application are completed.

What is your patient's disability?

Is the disability ambulatory? ☐ Yes ☐ No

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

Does your patient require additional space to access his/her vehicle due to the disability? If yes, describe:

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

What appliance does your patient use as an aid?

Is the significant disability permanent? ☐ Yes ☐ No

If you answered **No**, please answer this question: Is the significant disability likely to last less than six months?
☐ Yes ☐ No

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

Does your patient's disability affect their capacity to walk distances? ☐ Yes ☐ No

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? ☐ Yes ☐ No

If yes, please describe:

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

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, 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 | Phone Number