APPLICATION FOR DISABLED PARKING PERMIT

274 Gower Street, Preston
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darebin.vic.gov.au

the place to live

APPLICANT DETAILS

The Applicant is the person with the disability

To be completed by the Applicant or the Applicant's Agent.
Use BLOCK letters only

Office Use Only

No: / /

Expiry Date / /

New ☐
Renewal ☐

1. Surname

2. Given/Christian Names

Date of Birth

3. Address

Telephone Number

4. Is the Label for a: Driver ☐ Passenger Only ☐ Temporary Permit ☐

Question 5 should be complete by Driver only

5. Drivers Details
Drivers Licence Number

Expiry Date

6. What is your disability?

7. What appliances do you use as an aid?

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 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

PRIVACY INFORMATION

The collection and handling of personal information is in accordance with Council's Privacy Policy which is displayed on Council's website and available for inspection at, or collection from, Council's customer service centre/s

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 Persons' Parking Permit. A permit will not be issued unless all details on the application are completed.

9. What is your patient's disability?

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

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

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

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

	YES	NO
14. Is the significant disability permanent? If NO go to question 15. If YES go to question 16.		
15. Is the significant disability likely to last less than six months?		
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?		
17. Does your patient's disability affect their capacity to walk distances such that they require rest breaks?		
18. 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?		

19. Is the mobility aid consistent with at applicant's disability?

20. Additional supporting information known to you.

DECLARATION

I make this declaration and confirm 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 have sighted the below proof of the applicants identity and verify the applicants identity.

APPLICANTS DETAILS

Applicants Surname

Given/Christian Names

Date of Birth

Address

* Document sighted

Document Number

Expiry Date

** Types of documents required for proof of identity include Drivers License, Pension Card, Medicare Card, etc.*

MEDICAL PRACTITIONER/SPECIALIST/CLINICAL PSYCHOLOGIST DETAILS

Name of Medical Practitioner/Specialist/Clinical Psychologist

Qualifications

Address

Telephone Number

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

Signature of Medical Practitioner/Specialist/Clinical Psychologist

Date

Name of Medical Practitioner/Specialist/Clinical Psychologist

Qualifications

Address

Telephone Number

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

NOTE: THIS AUTHORITY IS TO BE GIVEN TO THE MEDICAL PRACTITIONER/SPECIALIST MEDICAL PRACTITIONER CLINICAL PSYCHOLOGIST. TO BE FILED WITH THE PATIENT'S RECORDS.

Authorisation for Medical Practitioner/Specialist Medical Practitioner/Clinical Psychologist to be complete the application form.

Insert name of Practitioner.

Address

I hereby authorise you to complete my application for a Disabled Persons' Parking Permit and to forward it

to..(name of municipality).

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 required by the authorised Council officer.

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

Name in block letters	Date

LODGEMENT OF APPLICATION

Completed applications should be returned to – Darebin Traffic Services, PO Box 91, Preston VIC 3072.
For more information, contact Darebin Traffic Services on 8470 8888.