DISABLED PERSONS PARKING SCHEME – APPLICATION

MOUNT ALEXANDER SHIRE COUNCIL

***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 / /

1. Surname

2. Given Names

3. Address **Telephone Numbers**

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

Question 5 should be completed by Driver / Passenger Only

5. Driver Details

Driver's Licence No. Expiry Date

6. What is your Disability?

7. What appliance 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 returning 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

Disabled Person Parking Scheme

Privacy Notification

The information the Mount Alexander Shire Council is collecting from you is personal information for the purpose of the information Privacy Act 2000 and Health Records Act 2001.The Information is being collected in order to enable the issue of disabled Persons Parking Scheme Label. This information will be shared between your medical practitioner and council offices authorised to issue a disabled persons parking scheme label.
If you cannot provide or do not wish to provide the information sought, it will affect our

Ability to process you application. You may access or amend information held by council be contacting council's privacy
Officer, Mount Alexander Shire Council, P.O Box 185, Castlemaine 3450 or telephone 54711 700.

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

9. What is your patients disability?

10. Does your patients 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?

14. Is the significant disability permanent? YES ☐ NO ☐
If **NO** go to question 15. If **YES** go to question 16.

15. Is this 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 you patients disability affect their capacity to walk distance 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.

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 Number

An appropriate charge 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 BR FILED WITH THE PATIENT'S RECORDS.

Authorisation for 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 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 requested by the authorised Council officer.

Applicant's signature (or Applicant's Agent)

Date

Name in block letters

Date