



PARKING PERMIT APPLICATION FORM

Tel: (250) 746-3930
Fax: (250) 746-3662
Email: cvilrc.bc.ca
Website: www.cvilrc.bc.ca



#103 - 121 First Street Duncan, BC, V9L 1R1

PART A: TO BE COMPLETED BY THE APPLICANT (please print)

APPLICANT'S FIRST NAME(S)		FAMILY OR LAST NAME	
MAILING ADDRESS (Apt. No., PO Box or RR#)		(Number & Street)	
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER
DATE OF BIRTH _____		<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE
YEAR MONTH DAY			

PART B: CONDITIONS FOR PARKING PERMIT HOLDERS

- Only one permit per Applicant will be issued. Permits issued for Permanent Disabilities must be renewed every three years. Temporary permits will be valid for a period of time as determined by your physician (maximum one year). **All personal information will remain strictly confidential.**
- It is the applicant's responsibility to ensure that his/her physician (only) has completed PART D (on the back of this form). The applicant is responsible for ensuring this form is completed and for any charges made for its completion. All applications are subject to eligibility criteria.
- I agree to be responsible for the appropriate use of the permit. I understand that only I am permitted to use this permit. I understand the information above and hereby authorize the release of any information requested with respect to this application.

SIGNATURE OR MARK (X) OF APPLICANT _____ DATE _____
OR POWER OF ATTORNEY OR LEGAL GUARDIAN*

*Power of attorney / legal guardian to sign only if applicant cannot be responsible for a legal permit

TO BE COMPLETED IF SIGNED BY POWER OF ATTORNEY OR LEGAL GUARDIAN

APPLICANT'S FIRST NAME(S)		FAMILY OR LAST NAME	
MAILING ADDRESS (Apt. No., PO Box or RR#)		(Number & Street)	
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER

RELATIONSHIP TO APPLICANT

PART C: PAYMENT (if you submit this application by mail, please do not send cash)

PROCESSING FEE:

PERMANENT \$23.00 TEMPORARY \$18.00 ORGANIZATION \$25.00
and VISITOR

(There is a processing fee charged on replacement lost/stolen/broken parking placards)

ENCLOSED - PAYABLE TO CIL Cash Money Order Cheque

LAST NAME & INIT.:	<input type="text"/>	PERMIT #:	<input type="text"/>
DISABILITY CODE:	<input type="text"/>	EXPIRES:	<input type="text"/>
PROCESSED BY:	<input type="text"/>	TYPE:	<input type="checkbox"/> PERM. <input type="checkbox"/> TEMP.
<i>Shaded Area Is For Office Use Only</i>		DATE:	<input type="text"/>

PART D: TO BE COMPLETED BY AN AUTHORIZED MEDICAL DOCTOR (please print)

GIVE MEDICAL NAME OF MOBILITY DISABILITY

HOW DOES THIS LIMIT MOBILITY? (Check all that apply)

- CANNOT WALK A DISTANCE GREATER THAN 100 METRES LEGALLY BLIND

PROGNOSIS

This patient is experiencing a mobility disability that is (CHECK ONE ONLY):

- PERMANENT** (Permit must be renewed every 3 years)
- TEMPORARY** 3 Months 6 Months 1 year
- ORGANIZATION**

CERTIFICATION

For the above reasons, it is my opinion that the patient has a mobility disability that poses a risk to their health by walking 100 metres. I hereby certify that to my knowledge, the above information is true and correct.

SIGNATURE OF THE MEDICAL DOCTOR

DATE

Note: Stamps or photocopies will not be accepted.

PHYSICIAN'S NAME (Please Print)		MSP #	ADDRESS STAMP
ADDRESS (Apt. No., PO Box or RR#) (Number & Street)			
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER

As a non-profit, charitable organization, all money received is used for programs and services which improve the quality of life for the disabled community. Donations of \$20.00 or more receive a tax receipt for income tax purposes. Please consider donating today.

AMOUNT DUE:

Permanent Parking Placard Fee (\$23.00) _____

Temporary Parking Placard Fee (\$18.00) _____

Organization Parking Placard Fee (\$25.00 for one year) _____

Bumper Sticker @ \$2.00 each: Quantity: _____

Donation: _____

TOTAL AMOUNT ENCLOSED: _____
