



# Parking Permit Application Form

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531 Canada Avenue , Duncan BC, V9L 1T8



## 1. Applicants Information

Have you applied for a parking permit before? YES <input type="checkbox"/> NO <input type="checkbox"/>				If yes, permit #	
APPLICANTS FIRST NAME(S)		MIDDLE NAME(S)		FAMILY OR LAST NAME	
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
TELEPHONE NUMBER					
FEMALE <input type="checkbox"/>		MALE <input type="checkbox"/>		DATE OF BIRTH (YY/MM/DD)	
EMAIL ADDRESS:					

## 2. Physicians Assessment

\*Please note; if you do not have a Physician, a Nurse Practitioner or Occupational Therapist may be considered

APPLICANTS NAME (Should be the same information as applicant in step 1)		
MEDICAL NAME OF DISABLING CONDITION(S)		
HOW DOES THIS LIMIT MOBILITY? (Check all that apply)		
<input type="checkbox"/> CANNOT WALK A DISTANCE GREATER THAN 100 METRES		<input type="checkbox"/> LEGALLY BLIND
<b>PROGNOSIS</b> This patient is experiencing a mobility disability that is (CHECK ONE ONLY): <input type="checkbox"/> <b>PERMANENT</b> (Permit must be renewed every 3 years) <input type="checkbox"/> <b>TEMPORARY</b> <b>1 year</b>		*Please note that should a temporary permit holder require a longer period of recovery the applicant, will have to reapply after the date specified with a new form
<b>CERTIFICATION</b> For the above reasons, it is my opinion that the patient has a mobility impairment 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 (Nurse Practitioner or OT)		DATE
<b>Note: Stamps or photocopies will not be accepted.</b>		
PHYSICIAN'S NAME (Please Print)	MSP #	ADDRESS STAMP
ADDRESS (Apt. No., PO Box or RR#)                      (Number & Street)		
CITY	PROVINCE	POSTAL CODE
TELEPHONE NUMBER		

**Please note: Only 1 parking permit may be issued to each individual.**

LAST NAME & INITIAL:	<input type="text"/>	PERMIT #:	<input type="text"/>
EMAIL:	<input type="text"/>	EXPIRES:	<input type="text"/>
PROCESSED BY:	<input type="text"/>	TYPE:	<input type="checkbox"/> PERM. <input type="checkbox"/> TEMP.
<b>SHADED AREA FOR OFFICE USE ONLY</b>		DATE:	<input type="text"/>

### 3. Important information about your parking permit

\*Permits issued for permanent disabilities must be renewed every three years. \*Temporary permits will be valid for a period of time as determined by the physician (for a maximum 1 year). \*It is the applicant's responsibility to ensure his/her physician, OT or Nurse Practitioner has completed PART 2.

By submission of this signed form, I agree to be responsible for the appropriate use of the permit, and I understand it is for my use only. I understand the CIL may contact my medical doctor to verify the nature of my disability and my eligibility for a permit. Furthermore, I understand that information collected by CIL, may be used by CIL or an enforcement officer to fulfill any legal obligations. Otherwise all personal information will remain strictly confidential.

- Please be advised that the permit is for your sole use only. This is not a permit for every family member to use.
- Also note, that when you use your permit, you need to have ID on your person, so that any enforcement officer may confirm the details on your permit are indeed the same as your ID.
- If we receive any complaints about the misuse or abuse of your parking permit, it could result in the permit being cancelled, and also jeopardise any future Parking Permits being issued
- At the same time, if you witness any misuse or abuse of a parking permit, please make a note of the permit number, and contact our office with details of the incident, so that we may take further action.

### 4. Signature

**I HAVE READ AND UNDERSTOOD THE CONDITIONS OF MY PARKING PERMIT**

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

**X** \_\_\_\_\_ DATE \_\_\_\_\_

POWER OF ATTORNEY/LEGAL GUARDIAN TO SIGN ONLY IF APPLICANT CANNOT BE RESPONSIBLE FOR PERMIT

TO BE COMPLETED IF SIGNED BY POWER OF ATTORNEY OR LEGAL GUARDIAN			
FIRST NAME		FAMILY OR LAST NAME	
MAILING ADDRESS (Apt. No., PO Box or RR#)		(Number & Street)	
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER
RELATIONSHIP TO APPLICANT			

### 5. Payment and Donation opportunity

Amount due:     Permanent \$25.00     Temporary \$23.00     Replacement \$25.00     Bumper Sticker \$2.00 each

DONATIONS ARE GRATEFULLY ACCEPTED \$\_\_\_\_\_ \*PLEASE MAKE CHECKS PAYABLE TO: Cowichan Independent Living  
 Donations of \$20 or more receive a tax receipt

**TOTAL PAYMENT \$\_\_\_\_\_**

\*As a non-profit charitable organization all donations are gratefully accepted and contribute significantly towards providing services, skills training and information to persons with disabilities to enable them to lead more independent lives. We thank you for any donation you may contribute.

Method of Payment     Cheque     Money Order     Cash     Visa     Mastercard

Card Number \_\_\_\_\_ Expiry Date: \_\_\_\_\_/\_\_\_\_\_

Signature \_\_\_\_\_