Parking Permit Application Form

Tel:(250) 746-3930
Fax:(250) 746-3662
Email: cvilrc@cvilrc.bc.ca
Website: www.cvilrc.bc.ca
531 Canada Avenue , Duncan BC, V9L 1T8

1. Applicants Information

Have you applied for a parking permit before? YES ☐ NO ☐			If yes, permit #
APPLICANTS FIRST NAME(S)	MIDDLE NAME(S)		FAMILY OR LAST NAME
MAILING ADDRESS			
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER
FEMALE ☐ MALE ☐	DATE OF BIRTH (YY/MM/DD)		EMAIL ADDRESS (we are going paperless)

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)

☐ 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** **1 year**

*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

CERTIFICATION

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

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

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

LAST NAME & INITIAL:		**PERMIT #:**	
EMAIL:		**EXPIRES:**	
PROCESSED BY:		**TYPE:** ☐ **PERM.** ☐ **TEMP.**	
SHADED AREA FOR OFFICE USE ONLY		**DATE:**	

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

X _____ DATE _____

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

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

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 $30.00 ☐ Temporary $25.00 ☐ Replacement $30.00 ☐ 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 _____