

# Disabled Persons Parking Scheme Application

Applicant Details			
<b>Surname</b>		<b>First Name</b>	
<b>Postal Address</b>			
<b>Suburb</b>		<b>Post Code</b>	
<b>Phone</b>		<b>Mobile</b>	
<b>Date of Birth</b>			
<b>Who is this label for?</b> (Please tick your answer)	<input type="checkbox"/> Driver/passenger - please provide Driving licence no: _____ <input type="checkbox"/> Passenger only <input type="checkbox"/> Corporation <input type="checkbox"/> Temporary permit		
<b>What is your disability?</b>			
<b>What appliances do you use as an aid?</b>			

## Conditions of use of a Disabled Person's Parking Permit

- A permit is not valid beyond its expiry date or if the expiry date or the permit number are not legible
- The parking entitlements applicable to the permit apply anywhere in Victoria. Reciprocal arrangements between States which have been agreed to by the Australian Transport Advisory Council also apply.
- The permit **must be clearly displayed at the left side of the front windscreen**, with the expiry date and permit number visible from the outside of the vehicle.
- A driver using the permit must either be the permit holder or must be parking the vehicle for the convenience of the permit holder who needs to enter or leave the vehicle.
- The permit remains the property of the issuing council, and must be returned within seven (7) days of notification of such return being required.
- Provided no other restrictions on parking are breached, a vehicle correctly displaying a valid disabled person's parking permit may be parked either:
  - in a parking area or bay designated for use by people with disabilities, for the time and parking fee specified for that area, if applicable; or
  - for twice the specified time for any parking area or bay not designated for use by classes of persons or lasses of vehicles, upon payment or any initial parking fee, if applicable.

## Applicant Agreement

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 with 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.

<b>Signature of Applicant</b>		<b>Date</b>	
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## Statement for completion by a medical practitioner/specialist/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 Person's Parking Permit. A permit will not be issued unless all details on the application are completed.

<b>What is you patient's disability?</b>	
<b>Is the disability permanent?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, will the disability last longer than six month	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What type of aid does the applicant use due to the disability?</b>	
<b>Does your patient's disability result in extreme danger to themselves or others in a public place without the continuous attendance of a caregiver?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Does your patient's disability affect their capacity to walk distances such that they require rest breaks?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Additional supporting information known to you (This information should provide actual details which may assist your patient in obtaining a disabled parking label)</b>	
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### 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.

<b>Name of medical practitioner/specialist/clinical psychologist</b>	
<b>Qualifications</b>	
<b>Address</b>	
<b>Phone Number</b>	
<b>Signature of medical practitioner/specialist/clinical psychologist</b>	<b>Date</b>

*Privacy Statement: The Surf Coast Shire considers that the responsible handling of personal information is a key aspect of democratic governance, and is strongly committed to protecting an individual's right to privacy. Council will comply with the Information Privacy Principles as set out in the Privacy and Data Protection Act, 2014. The information will not be disclosed to any other party unless Council is required to do so by law.*

### Patient Authority

**This authority is to be given to and retained by the Medical Practitioner/Specialist Medical Practitioner/Clinical Psychologist - This authority should be retained by the Doctor and filed with the patients records**

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

<b>Name of practitioner</b>	
<b>Address</b>	

I hereby authorise you to complete my application for a Disabled Person's Parking Permit and to forward it to the Surf Coast Shire.

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.

<b>Name in block letters</b>		<b>Date</b>	
<b>Applicant's signature (or agent)</b>		<b>Date</b>	