

PARKING PERMIT APPLICATION – INDIVIDUAL



NANAIMO DISABILITY RESOURCE CENTRE
 #2-4166 Departure Bay Rd.
 Nanaimo, BC, V9T 4B7
 Hours: Monday – Friday
 8:30am – 4:00pm

Phone: 250-758-5547
 Website: www.ndrc.info



OFFICE USE ONLY	
Permit No.	_____
Renewal No.	_____
Renewal No.	_____
Renewal No.	_____

PART 1 - APPLICANT INFORMATION – PLEASE PRINT

FIRST NAME	MIDDLE NAME	FAMILY OR LAST NAME	
MAILING ADDRESS			
CITY	PROVINCE	POSTAL CODE	DATE OF BIRTH DAY: _____ MONTH: _____ YEAR: _____
HOME ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)			EMAIL ADDRESS
TELEPHONE (HOME)	TELEPHONE NUMBER <input type="checkbox"/> WORK <input type="checkbox"/> CELL		<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE

You may receive periodic mailing from us with information on our services. If you do not wish to receive such mailings please let us know.
 No, I would not like to receive periodic e-mailings from NDRC. Yes, I would like to receive renewal letters by email.

Have you applied for a NDRC permit before? YES NO **If yes, Permit # _____ or approximately how long ago? _____**

IMPORTANT INFORMATION ABOUT YOUR PERMIT

Only one permit per applicant will be issued. Permits issued for permanent disabilities must be renewed every three years. Temporary disability permits will be valid for a period of time as determined by the medical professional (6 months or 1 year). **It is the applicant's responsibility to ensure his / her medical professional has completed PART 2.** Fees paid to the medical professional are for completing the form, not the permit. By submission of this signed form, I agree to be responsible for the appropriate use of the permit, and I understand the permit is for my personal use only. I understand the NDRC may contact my medical professional to verify the nature of my disability and my eligibility for a permit. Furthermore, I understand that information collected by NDRC, may be used by NDRC or an enforcement officer to fulfill any legal obligations. Otherwise all personal information will remain strictly confidential.

I HAVE READ AND UNDERSTOOD THE CONDITIONS OF MY PARKING PERMIT

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

SIGNATURE: _____ DATE: _____
 Power of Attorney or Legal Guardian should only sign if applicant cannot be responsible for his / her permit.

APPLICANT'S REPRESENTATIVE (IF ANY)

FIRST NAME	FAMILY OR LAST NAME	RELATIONSHIP TO DISABLED PERSON:
MAILING ADDRESS <input type="checkbox"/> Send all correspondence to this mailing address		<input type="checkbox"/> FATHER/ MOTHER <input type="checkbox"/> SPOUSE <input type="checkbox"/> POWER OF ATTORNEY <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> OTHER (SPECIFY): _____
CITY	PROVINCE	POSTAL CODE
TELEPHONE (HOME)	TELEPHONE <input type="checkbox"/> WORK <input type="checkbox"/> CELL	
		EMAIL ADDRESS

All information must be completed for processing. When the application is completed by a medical professional, it must be submitted to NDRC within 3 months or a new application will be required.

OFFICE USE ONLY

Permit No. _____	<input type="checkbox"/> Perm. <input type="checkbox"/> Temp.	Exp _____ (M/Y)	Amt _____	Pmt Type _____	Rec'd by _____	W P M	Data Entry _____
Permit No. _____	<input type="checkbox"/> Perm. <input type="checkbox"/> Temp.	Exp _____ (M/Y)	Amt _____	Pmt Type _____	Rec'd by _____	W P M	Data Entry _____
Permit No. _____	<input type="checkbox"/> Perm. <input type="checkbox"/> Temp.	Exp _____ (M/Y)	Amt _____	Pmt Type _____	Rec'd by _____	W P M	Data Entry _____
Permit No. _____	<input type="checkbox"/> Perm. <input type="checkbox"/> Temp.	Exp _____ (M/Y)	Amt _____	Pmt Type _____	Rec'd by _____	W P M	Data Entry _____

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PART 2 - ASSESSMENT BY A REGISTERED: **PHYSIOTHERAPIST** **OCCUPATIONAL THERAPIST**
 DOCTOR **CHIROPRACTOR** **CLINIC-BASED NURSE PRACTITIONER**
 PODIATRIST / CHIROPODIST

APPLICANT'S NAME _____

MEDICAL NAME OF DISABLING CONDITION(S) _____

<p>APPLICANT ELIGIBILITY (PLEASE CHECK ONE)</p> <p><input type="checkbox"/> Applicant has a disability that limits mobility</p> <p><input type="checkbox"/> Applicant cannot walk 100 metres without risk to health</p>	<p><input type="checkbox"/> Applicant requires the use of a mobility aid such as a wheelchair, scooter, walker, or crutches</p> <p><input type="checkbox"/> Other (please specify) _____</p>
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PROGNOSIS
 This patient is experiencing a mobility impairment which is a (CHECK ONE ONLY)

PERMANENT DISABILITY – Permit must be renewed every 3 years

TEMPORARY DISABILITY – Patient should be reassessed after: 6 MONTHS 1 YEAR

NAME OF CERTIFYING MEDICAL PROFESSIONAL - PRINT _____	TELEPHONE NUMBER _____	FAX NUMBER _____
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<p>MEDICAL PROFESSIONAL AUTHORIZATION</p> <p>For the above reasons, it is in my opinion that the patient has an impairment that poses a risk to their health by walking 100 meters. I hereby certify that, to my knowledge, the above information is true and correct</p> <p>MEDICAL PROFESSIONAL SIGNATURE: _____ Please note: Stamps or photocopies will not be accepted.</p> <p>DATE: _____ MSP NUMBER: _____</p>	<p>MEDICAL PROFESSIONAL'S ADDRESS PRINT OR STAMP</p>
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PAYMENT INFORMATION

<p>PROCESSING FEE \$23.00 <input type="checkbox"/> if paying in person OR \$25.00 <input type="checkbox"/> if permit to be mailed to applicant Please note: permit fees are non-refundable and subject to change.</p>	<p>= \$ _____</p>
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<p>I would like to donate \$ _____ .</p> <p>Any donations are gratefully received by NDRC, and contribute significantly towards providing services, skills and information to persons with disabilities, thus enabling them to lead more independent lives. We thank you for any donation you may contribute.</p> <p><input type="checkbox"/> I request a Tax Receipt for my donation. Tax receipts only issued for amounts of \$20 or more Charity registration number: 128031721RR0001</p>	<p>= \$ _____</p>
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<p>METHOD OF PAYMENT: Please make cheques / money orders payable to NDRC</p> <p><input type="checkbox"/> Cheque / Money Order <input type="checkbox"/> Cash <input type="checkbox"/> Debit (In Office Only)</p> <p>Card number: _____ Expiry date: ____ / ____</p> <p><input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Amex</p> <p>Signature: _____</p>	<p>TOTAL:</p> <p>= \$ _____</p>
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