

PARKING PERMIT APPLICATION – INDIVIDUAL



NANAIMO DISABILITY RESOURCE CENTRE
 #2-4166 Departure Bay Rd.
 Nanaimo, BC, V9T 4B7
 Hours: Monday – Friday
 9:00-12:00 and 12:30-3:30

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 <input type="checkbox"/> I'd like to receive renewal letters by email.
TELEPHONE (HOME)	TELEPHONE NUMBER <input type="checkbox"/> WORK <input type="checkbox"/> CELL		<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE

NO, I would not like to receive periodic e-mailings from NDRC.

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** for the permit fee. By submission of this original 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: <input type="checkbox"/> SON/DAUGHTER <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): _____
MAILING ADDRESS <input type="checkbox"/> Send all correspondence to this mailing address		
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. Only original signed forms will be accepted.

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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: <input type="checkbox"/> MEDICAL DOCTOR <input type="checkbox"/> PODIATRIST			<input type="checkbox"/> PHYSIOTHERAPIST <input type="checkbox"/> CHIROPRACTOR	<input type="checkbox"/> OCCUPATIONAL THERAPIST <input type="checkbox"/> CLINIC-BASED NURSE PRACTITIONOR
APPLICANT'S NAME				
MEDICAL NAME OF DISABLING CONDITION(S)				
APPLICANT ELIGIBILITY (PLEASE CHECK ONE) <input type="checkbox"/> Applicant has a disability that limits mobility <input type="checkbox"/> Applicant cannot walk 100 metres without risk to health			<input type="checkbox"/> Applicant requires the use of a mobility aid such as a wheelchair, scooter, walker, or crutches <input type="checkbox"/> Other (please specify) _____	
PROGNOSIS This patient is experiencing a mobility impairment which is a (CHECK ONE ONLY)				
<input type="checkbox"/> PERMANENT DISABILITY – Permit must be renewed every 3 years <input type="checkbox"/> TEMPORARY DISABILITY – Patient should be reassessed after: <input type="checkbox"/> 6 MONTHS <input type="checkbox"/> 1 YEAR				
NAME OF CERTIFYING MEDICAL PROFESSIONAL – PRINT LEGIBLY		TELEPHONE NUMBER		FAX NUMBER
MEDICAL PROFESSIONAL AUTHORIZATION 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 meters. I hereby certify that, to my knowledge, the above information is true and correct MEDICAL PROFESSIONAL SIGNATURE: _____ Please note: Stamps or photocopies will not be accepted. DATE: _____ MSP # or equivalent: _____ REQUIRED			MEDICAL PROFESSIONAL'S ADDRESS PRINT OR STAMP - REQUIRED	
PAYMENT INFORMATION				
PROCESSING FEE (THIS IS SEPARATE FROM THE DOCTOR'S SIGNING FEE) \$25.00 <input type="checkbox"/> if paying in person OR \$27.00 <input type="checkbox"/> if permit to be mailed to applicant Please note: permit fees are non-refundable and subject to change.			= \$ _____	
I would like to donate \$ _____ 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. Tax receipts automatically issued for amounts of \$20 or more Charity registration number: 128031721RR0001			= \$ _____	
METHOD OF PAYMENT: Please make cheques / money orders payable to NDRC <input type="checkbox"/> Cheque / Money Order <input type="checkbox"/> Cash <input type="checkbox"/> Debit (In Office Only) Card number: _____ Expiry date: _____ / _____ <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Amex Signature: _____			TOTAL: = \$ _____	