DISABLED PERSONS PARKING SCHEME APPLICATION

Banyule City Council - PO Box 94 Greensborough VIC 3088

The Applicant is the person with the disability

***Please allow at least 7 working days for the permit to be posted to you**

To be completed by Applicant or Applicant's Agent USE BLOCK LETTERS

Office Use Only	Date
Category	/ /
Permit No	
Expiry Date	/ /
NAR no.	

New ☐ Renewal ☐ Replacement ☐ (Please attach explanation)

1. Title:	Surname:	Given/Christian Names:
Date of Birth: ___/___/_____	Telephone 1:	Telephone 2:
2. Current Residential Address: Postcode		
3. If you have changed your address would you like your details to be updated for any other Council services?	Rates	Homecare / Other (Please Specify)
If your address has changed - notate Previous Residential Address: Postcode		

4. **Is the label for a:**

Driver	
Passenger only	
Temporary Permit	

5. **If yes** Licence No: Expiry Date:

6. What is your disability?

7. What appliance do you use as an aid?

8. **Declaration by Applicant**

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 within seven (7) days of notification of such return being required. The Applicant's agent may sign and take full legal responsibility on the Applicant's behalf. Council respects all personal and confidential information you give and will do everything possible to protect information from unauthorised access, loss or misuse. Information collected from you is required for the delivery of Council Services in accordance with Council's powers, functions and purposes under the Local Government Act 1989 and other relevant legislation. It may also be used by Council to conduct research and customer satisfaction surveys so that we may better understand community needs and can improve service delivery.

I …… (please print) understand that the information provided above will be used in accordance with relevant legislation and declare that this information is correct to the best of my knowledge.

Applicant's signature (or Applicant's Agent) Date

FOR COMPLETION BY A MEDICAL PRACTITIONER/SPECIALIST OR 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 Persons' Parking Permit. Please complete in full.

9. What is your patient's disability?

10. Does your patient's disability require him/her to continually use an appliance for support to aid his/her mobility?

11. Does your patient require additional space to access his/her vehicle due to the disability?

12. Does the use of the aid cause your patient the need to use this space?

13. What appliance does your patient use as an aid?

14. Is the significant disability permanent? YES NO
If **NO** go to question 15. If **YES** go to question 16

15. **Is the significant disability likely to last more than six months** YES NO

16. Does your patient's disability result in extreme danger to themselves or others in a public place without the continuous attendance of a caregiver? YES NO

17. Does your patient's disability affect their capacity to walk distances such that they require rest breaks? YES NO

18. Does the disability affect their capacity to walk to such an extent that it may become severely injurious (as opposed to inconvenient) to their health? YES NO
If yes, please explain

19. Is the mobility aid consistent with the applicant's disability?

20. Additional supporting information known to you.

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.

Signature of Medical Practitioner/Specialist/Clinical Psychologist

Date

Name of Medical Practitioner/Specialist/Clinical Psychologist

Qualifications

Address

Telephone Number

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