PARKING PERMIT APPLICATION – INDIVIDUAL

NDRC
PATHWAYS TO INDEPENDENCE

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:
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
☐ I'd like to receive renewal letters by email.

TELEPHONE (HOME)	TELEPHONE NUMBER ☐ WORK ☐ CELL	Gender

☐ **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 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. *The permit remains the property of NDRC and can be revoked at any time if in the opinion of NDRC the permit holder is not taking proper care of the permit including altering, defacing, duplicating or allowing others to use it.*

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: ☐ SON/DAUGHTER ☐ FATHER/ MOTHER ☐ SPOUSE ☐ POWER OF ATTORNEY ☐ LEGAL GUARDIAN ☐ OTHER (SPECIFY):_____________

MAILING ADDRESS ☐ Send all correspondence to this mailing address

CITY	PROVINCE	POSTAL CODE

TELEPHONE (HOME)	TELEPHONE ☐ WORK ☐ 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.

OFFICE USE ONLY

Permit No. __________	☐ Perm. ☐ Temp.	Exp ________ (M/Y)	Amt ____	Pmt Type_____	Rec'd by ____	W P M	Data Entry _____
Permit No. __________	☐ Perm. ☐ Temp.	Exp ________ (M/Y)	Amt ____	Pmt Type_____	Rec'd by ____	W P M	Data Entry _____
Permit No. __________	☐ Perm. ☐ Temp.	Exp ________ (M/Y)	Amt ____	Pmt Type_____	Rec'd by ____	W P M	Data Entry _____
Permit No. __________	☐ Perm. ☐ 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:		
☐ **MEDICAL DOCTOR**	☐ **PHYSIOTHERAPIST**	☐ **OCCUPATIONAL THERAPIST**
☐ PODIATRIST	☐ **CHIROPRACTOR**	☐ **CLINIC-BASED NURSE PRACTITIONER**

APPLICANT'S NAME

MEDICAL NAME OF DISABLING CONDITION(S)

APPLICANT ELIGIBILITY (PLEASE CHECK ONE)

☐ Applicant has a disability that limits mobility

☐ Applicant cannot walk 100 metres without risk to health

☐ Applicant requires the use of a mobility aid such as a wheelchair, scooter, walker, or crutches

☐ Other (please specify) _____

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 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)
$31.00 ☐ if paying in person OR $33.00 ☐ 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

☐ Cheque / Money Order ☐ Cash ☐ Debit (In Office Only)

Card number: _____ Expiry date: _____ / _____

☐ Visa ☐ MasterCard ☐ Amex

Signature:_____

TOTAL:

= $ _____