



## PARKING PERMIT APPLICATION

PART 1 - Applicant Information – PLEASE PRINT					
First Name		Middle Name		Family or Last Name	
Mailing Address					
City		Prov.	Postal Code	DOB	
				Day:	Month:                      Year:
Telephone (Primary)		Telephone Number <input type="checkbox"/> Other _____		Email Address	
				<input type="checkbox"/> Yes! I'd like renewal a reminder by email.	
LEGAL REPRESENTATIVE (IF ANY)					
Name		Relationship To Applicant: <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Caregiver <input type="checkbox"/> Other: _____			
PART 2 - MEDICAL PROFESSIONAL DECLARATION					
<input type="checkbox"/> Medical doctor		<input type="checkbox"/> Physiotherapist		<b>Applicant Eligibility (please check one)</b> <input type="checkbox"/> applicant cannot walk 100 meters without risk to health <input type="checkbox"/> applicant requires the use of a mobility aid <input type="checkbox"/> other (please specify) _____	
<input type="checkbox"/> Occupational Therapist		<input type="checkbox"/> Podiatrist			
<input type="checkbox"/> Chiropractor		<input type="checkbox"/> Nurse Practitioner			
<input type="checkbox"/> Specialist _____					
<b>Prognosis</b> This patient is experiencing a mobility impairment: <input type="checkbox"/> Permanent disability. Renewable every 3 years. No further authorization needed. <input type="checkbox"/> Temporary disability. 1 year reassessment by medical professional					
Name of certifying medical professional – <b>print legibly</b>			Phone		Fax number
Medical professional authorization  Medical professional signature: _____ Please note: stamps or photocopies will not be accepted.  Date: _____ msp # or equivalent: _____ <b>required</b>				Medical professional's address Print or stamp – <b>required</b>	

Office Use Only: Person ID #: \_\_\_\_\_

**PART 3 - PAYMENT INFORMATION****1. PROCESSING FEE** (not the same as the medical professional's signing fee) **\$35.00** (in person) **OR**  **\$39.00** (mailed within 48 hours)

\$ \_\_\_\_\_

**2. WE ARE A CHARITY!**

NDRC is an independent charity that depends on donations to provide vital services for seniors and those with disabilities. Your gift would support our parking permit program, computer school, tax program or disability resource navigation.

**Yes! I would like to top up my payment by:**

 \$20    \$50    \$75    \$ \_\_\_\_\_

Donations issued for gifts of more than \$20. Charity #: 128031721RR0001

**THANK YOU!**

\$ \_\_\_\_\_

**3. METHOD OF PAYMENT:**

Please make cheques / money orders payable to NDRC

Please note: permit fees are non-refundable and subject to change.

 Cheque / Money Order    Cash    Debit (In Office Only)

Card number: \_\_\_\_\_ Exp. date: \_\_\_\_ / \_\_\_\_

 Visa    MasterCard    Amex

Signature: \_\_\_\_\_

**TOTAL:**

\$ \_\_\_\_\_

**PART 4 – RETURN COMPLETED FORM AND PAYMENT TO:**

**Nanaimo Disability Resource Centre (NDRC)**  
#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  
Fax: 236-362-3028  
Email: Parking@ndrc.info  
Web: ndrc.info

**IMPORTANT INFORMATION ABOUT YOUR PERMIT**

- Only one permit per applicant will be issued. Permits issued for permanent disabilities must be renewed every three years.
- Applicants are responsible for ensuring their medical professional has completed Part 2.
- I understand NDRC may contact my medical professional to verify the nature of my disability and my eligibility for a permit.
- 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.
- 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.