



# PARKING PERMIT PROGRAM FOR PEOPLE WITH DISABILITIES APPLICATION FORM

Permit No. _____
Renewal No. _____
Renewal No. _____
Renewal No. _____

**Part A To be completed by the applicant or designate in the name of the person with the disability (PLEASE PRINT)**

FIRST NAME OF DISABLED PERSON	MIDDLE NAME	FAMILY OR LAST NAME
BUSINESS NAME, IF APPLICABLE		
MAILING ADDRESS (P.O. Box / R.R. # / Apt. No., Number and Street)		HOME ADDRESS
CITY, TOWN OR VILLAGE	PROVINCE	POSTAL CODE
TELEPHONE NUMBER (Home)		
DATE OF BIRTH (MM/DD/YY)	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	TELEPHONE NUMBER (Work/Cell)

**IT IS AN OFFENSE TO MAKE A FALSE OR MISLEADING STATEMENT IN THIS APPLICATION**

Only one permit will be issued per applicant. Permits issued for permanent disabilities must be renewed every three years. Permits which are not issued for permanent disabilities will be valid for a period of time as determined by the physician (maximum one year). The applicant is responsible for ensuring this form is completed and for any charges made for its completion. It is the applicant's responsibility to ensure that her/his physician has completed this form. The applicant is responsible for sending the completed form to NRDRRC at the address given below. I agree to be responsible for the appropriate use of the permit. I understand the information above and hereby authorize the release of any information requested with respect to this application form to the NRDRRC Parking Program for People with Disabilities.

\_\_\_\_\_  
**SIGNATURE OR MARK (X) OF APPLICANT OR DESIGNATE**

\_\_\_\_\_  
**DATE**

**To be completed if signed by Power of Attorney or Legal Guardian**

GIVEN NAME(S)	FAMILY OR LAST NAME	HOME ADDRESS (Apt No., Number and Street)	
CITY, TOWN OR VILLAGE	PROVINCE	POSTAL CODE	TELEPHONE NUMBER (Home)
RELATIONSHIP TO APPLICANT:			

**PROCESSING FEE IS \$20.00 FOR A PERMANENT OR TEMPORARY PARKING PERMIT.**

WE ACCEPT DEBIT, VISA AND MASTERCARD - IN THE OFFICE ONLY  
PLEASE MAKE ALL CHEQUES/MONEY ORDERS PAYABLE TO:  
**NANAIMO & REGION DISABILITY RESOURCE CENTRE or NDRC**  
#2 – 4166 Departure Bay Road, Nanaimo, B.C. V9T 4B7 Phone: 250 758-5547  
Website: [www.nrdrcc.org](http://www.nrdrcc.org) FAX: 250 758-5504 email: [parking\\_placards@nrdrcc.org](mailto:parking_placards@nrdrcc.org)

**\$20.00 FEE IS ENCLOSED**

To support our programs and services, donations above the application fee are gratefully accepted.

**OFFICE USE ONLY. DO NOT WRITE BELOW THIS LINE.**

Permit No.1 # _____	Perm. <input type="checkbox"/> Temp. <input type="checkbox"/>	Exp Date ____ (MM/YY)	Amt Rec'd _____	Pmt Type _____	Rec'd by _____	Data Entry _____
Permit No.2 # _____	Perm. <input type="checkbox"/> Temp. <input type="checkbox"/>	Exp Date ____ (MM/YY)	Amt Rec'd _____	Pmt Type _____	Rec'd by _____	Data Entry _____
Permit No.3 # _____	Perm. <input type="checkbox"/> Temp. <input type="checkbox"/>	Exp Date ____ (MM/YY)	Amt Rec'd _____	Pmt Type _____	Rec'd by _____	Data Entry _____
Permit No. 4 # _____	Perm. <input type="checkbox"/> Temp. <input type="checkbox"/>	Exp Date ____ (MM/YY)	Amt Rec'd _____	Pmt Type _____	Rec'd by _____	Data Entry _____

**Part B to be completed by an authorized medical doctor (PLEASE PRINT)**

**APPLICANT'S NAME** (Should be the same as applicant in Part A – See Reverse)

**GIVE MEDICAL NAMES OF DISABLING CONDITION(S)**

**HOW DOES THIS IMPAIR MOBILITY?** (Check all that apply)

- CANNOT WALK A DISTANCE GREATER THAN 100 METRES
- REQUIRES AN EXTRA WIDE PARKING SPACE TO ENTER OR EXIT A VEHICLE
- REQUIRES THE USE OF MOBILITY AIDS IN ORDER TO TRAVEL ANY DISTANCE
- OTHER (please specify):

(Attach a separate sheet if more space is required)

**PROGNOSIS**

The patient is experiencing a mobility impairment which is **(Check one only)**:

- PERMANENT (\$20.00)** – Permit must be renewed every 3 years
- TEMPORARY (\$20.00)** - *Patient should be reassessed after:*  6 MONTHS  1 YEAR

**CERTIFICATION**

For the above reasons, it is my opinion that the patient should be eligible for a disabled person's parking permit. I hereby certify that to my knowledge, the above information is true and correct.

\_\_\_\_\_  
**SIGNATURE OF THE MEDICAL DOCTOR**

Note: Stamps or photocopies will not be accepted

\_\_\_\_\_  
**DATE**

**PHYSICIAN'S NAME** (PLEASE PRINT OR USE STAMP→)

**NAME & ADDRESS STAMP**

**ADDRESS** (Number and Street)

(P.O. Box or RR No.)

**CITY, TOWN OR VILLAGE**

**PROVINCE**

**POSTAL CODE**

**TELEPHONE NUMBER**



**Nanaimo & Region Disability Resource Centre**

#2 – 4166 Departure Bay Road, Nanaimo, BC V9T 4B7

Ph: (250) 758-5547 Fax: (250) 758-5504

Email: parking\_permits@nrdr.org Website: www.nrdr.org

