



# PARKING PERMIT PROGRAM FOR PEOPLE WITH DISABILITIES APPLICATION FORM

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

**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 (and Business name, if applicable)	MIDDLE NAME	FAMILY OR LAST NAME	
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 (D/M/Y/)	FEMALE <input type="checkbox"/>	MALE <input type="checkbox"/>	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/Work)
RELATIONSHIP TO APPLICANT:			

**PROCESSING FEE IS \$18.00 FOR A PERMANENT (3 YR) AND \$20.00 FOR A TEMPORARY PARKING PLACARD. THIS INCLUDES THE PERMIT.**

WE ACCEPT DEBIT, VISA AND MC (IN OFFICE ONLY). PLEASE MAKE ALL CHEQUES/MONEY ORDERS PAYABLE TO:

**NANAIMO & REGION DISABILITY RESOURCE CENTRE or NRDRRC**  
 #2 – 4166 Departure Bay Road, Nanaimo, B.C. V9T 4B7 Phone: 250 758-5547  
 Website: www.nrdrcc.org FAX: 250 758-5504 email: parking\_placards@nandrc.org

<input type="checkbox"/>	<b>\$18.00 FEE IS ENCLOSED</b>	Donations above the application fee will be gratefully accepted and will help improve our support and programs for the disabled community.
<input type="checkbox"/>	<b>\$20.00 FEE IS ENCLOSED</b>	

OFFICE USE ONLY. DO NOT WRITE IN THIS AREA						
Permit No. 1 # _____	Perm. <input type="checkbox"/> Temp. <input type="checkbox"/>	Exp Date _____ (M/Y)	Amt Rec'd \$ _____	Pmt type _____	Rec'd by _____	Data Entry _____
Permit No. 2 # _____	Perm. <input type="checkbox"/> Temp. <input type="checkbox"/>	Exp Date _____ (M/Y)	Amt Rec'd \$ _____	Pmt type _____	Rec'd by _____	Data Entry _____
Permit No. 3 # _____	Perm. <input type="checkbox"/> Temp. <input type="checkbox"/>	Exp Date _____ (M/Y)	Amt. Rec'd \$ _____	Pmt type _____	Rec'd by _____	Data Entry _____
Permit No. 4 # _____	Perm. <input type="checkbox"/> Temp. <input type="checkbox"/>	Exp Date _____ (M/Y)	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 SAME AS APPLICANT IN PART A - SEE REVERSE)

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GIVE MEDICAL NAMES OF DISABLING CONDITION(S)

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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
- OTHER (please specify):

(Attach a separate sheet if more space is required)

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PLEASE INDICATE MOBILITY AID(S) USED:

- CANE       WALKER       CRUTCHES       WHEELCHAIR
- LEG BRACE       N/A       OTHER

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**PROGNOSIS**

The patient is experiencing a mobility impairment which is (CHECK ONE ONLY):

**PERMANENT (\$18.00)**

**TEMPORARY (\$20.00):** *Patient should be reassessed after:*

6 MONTHS

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**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

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

NAME & ADDRESS STAMP

ADDRESS (Number and Street)

(P.O. Box or RR No.)

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CITY, TOWN

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@nrdrcc.org](mailto:parking_permits@nrdrcc.org)      Website: [www.nrdrcc.org](http://www.nrdrcc.org)

