



Victoria Disability Resource Centre
Promoting a new perspective on disability

APPLICATION FORM

Tel: (250) 595-0044
Fax: (250) 595-1512
parking@drcvictoria.com
www.drcvictoria.com
Hours 9 AM to 4 PM



PARKING PERMITS FOR PERSONS WITH DISABILITIES
817 A Fort Street, Victoria, BC V8W 1H6

PART A: TO BE COMPLETED BY THE APPLICANT (please print clearly)

Have you applied for a DRC parking permit before? YES NO If yes, Permit # _____

APPLICANT'S FIRST NAME(S)		FAMILY OR LAST NAME	
MAILING ADDRESS			
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER
DATE OF BIRTH	YEAR	MONTH	DAY
		<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE

PART B: CONDITIONS FOR PARKING PERMIT HOLDERS

- It is the applicant's responsibility to ensure that his/her physician has completed **PART D** (on the back of this form). The applicant is responsible for ensuring this form is completed and for any changes made for its completion. All applications are subject to eligibility criteria.
- **ONLY ONE PERMIT PER APPLICANT.** Permits issued for Permanent Disabilities must be renewed every three years. Temporary permits will be valid for a period of time as determined by your physician (maximum one year). All personal information will remain strictly confidential.
- I agree to be responsible for the appropriate use of the permit. I understand that only I am permitted to use this permit. I understand the information above and hereby authorize the release of any information requested with respect to this application.

SIGNATURE OR MARK (X) OF APPLICANT OR POWER OF ATTORNEY OR LEGAL GUARDIAN*

DATE

*Power of attorney/legal guardian to sign only if applicant cannot be responsible for a legal permit

TO BE COMPLETED IF SIGNED BY POWER OF ATTORNEY OR LEGAL GUARDIAN

FIRST NAME(S)		FAMILY OR LAST NAME	
MAILING ADDRESS			
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER
RELATIONSHIP TO APPLICANT			

LAST NAME & INIT:	<input type="text"/>	PERMIT #:	<input type="text"/>
ISSUED BY:	<input type="text"/>	EXPIRES:	<input type="text"/>
		TYPE:	<input type="checkbox"/> PERM. <input type="checkbox"/> TEMP.

SHADED AREA IS FOR DRC OFFICE USE ONLY

PART C: PAYMENT (if you submit this application by mail, do not enclose cash)PROCESSING FEE IS **\$20 AT THE DRC** or **\$22.00 BY MAIL** ENCLOSED - PAYABLE TO DRC

METHOD: <input type="checkbox"/> Credit Card <input type="checkbox"/> Cash <input type="checkbox"/> Debit Card <input type="checkbox"/> Cheque <input type="checkbox"/> Money Order	<input type="checkbox"/> VISA <input type="checkbox"/> M/C	EXPIRY DATE ____/____/____ Month / Year
CREDIT CARD NUMBER		

I ALSO WISH TO DONATE:
 \$5.00 and receive a MEMBERSHIP to the DRC.
 \$ _____
 Donations of \$20.00 or more receive tax receipt.

\$ _____
 THE TOTAL AMOUNT I AUTHORIZE

SIGNATURE

PART D: TO BE COMPLETED IN FULL BY AN AUTHORIZED MEDICAL DOCTOR

CERTIFYING MEDICAL DOCTOR must complete this section. Please note: As the authorizing medical professional, you are verifying this applicant has a disability that will pose a risk to their health by walking 100 meters. Your authorization entitles them to designated parking identification. Should there be misuse or abuse of the privileges associated with the issuance of this designated identification, you may be requested to verify the applicant's disability. The applicant is responsible for any and all costs incurred in the completion of this application.

APPLICANT'S NAME (SHOULD BE THE SAME AS APPLICANT IN PART A - SEE REVERSE)

PROGNOSIS (please note: this section must be completed)This patient is experiencing a mobility impairment that is (**CHECK ONE ONLY**):

- PERMANENT** (Permit must be renewed every 3 years)
 TEMPORARY (MAXIMUM of 1 year)

If **TEMPORARY**, please give the **EXACT** date by which the disability is likely to cease*:

MONTH: _____ AND YEAR: 20_____.

*PLEASE NOTE: Should a temporary permit holder require a longer period of recovery, he/she will have to reapply for a permit after the date specified.

CERTIFICATION – MUST BE COMPLETED IN FULL

For the above reasons, it is my opinion that the patient has a mobility impairment 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.

SIGNATURE OF THE MEDICAL DOCTOR

DATE

Original signature required.

PHYSICIAN'S NAME (Please Print)

MSP #

ADDRESS STAMP

ADDRESS

CITY

PROVINCE

POSTAL CODE

TELEPHONE NUMBER

Please Note:

Persons who have sensory impairments are not eligible for a permit unless they also have reduced mobility.

If you answer "yes" to any of the following questions below regarding your patient, the patient may be eligible for a permit:

- Is the applicant's disability classified as: neurological, musculoskeletal, cardiovascular, respiratory or other?
- Given the applicant's disability, does he or she have difficulty walking more than 100 meters?
- Does the applicant require the use of any of the following mobility aids: manual wheelchair, motorized wheelchair, motorized scooter, or walking aid (such as cane, walker, or crutches)?