



**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 will be issued. 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			

**PART C: PAYMENT (if you submit this application by mail, do not enclose cash)**

PROCESSING FEE IS \$18 AT THE DRC or \$20.00 BY MAIL  ENCLOSED - PAYABLE TO DRC

METHOD: <input type="checkbox"/> Credit Card	<input type="checkbox"/> VISA	EXPIRY DATE
<input type="checkbox"/> Cash <input type="checkbox"/> Debit Card	<input type="checkbox"/> M/C	_____/____/____
<input type="checkbox"/> Cheque <input type="checkbox"/> Money Order	CREDIT CARD NUMBER	Month / Year
I ALSO WISH TO DONATE:	\$ _____	_____
\$ _____	THE AMOUNT I AUTHORIZE	SIGNATURE

LAST NAME & INIT:

PERMIT #:

ISSUED BY:

EXPIRES:

**SHADED AREA IS FOR DRC OFFICE USE ONLY**

TYPE:  PERM.  TEMP.

**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 special parking identification. Should there be misuse or abuse of the privileges associated with the issuance of this special 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)

GIVE MEDICAL NAME OF CONDITION(S) CAUSING DISABILITY

HOW DOES THIS IMPAIR MOBILITY?

PLEASE DESCRIBE: \_\_\_\_\_  
\_\_\_\_\_

**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**

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

MONTH: \_\_\_\_\_ AND YEAR: 20\_\_\_\_. **MAXIMUM OF 1 YEAR.**

\*PLEASENOTE: 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**

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  
**Original signature required.**

\_\_\_\_\_  
DATE

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 the answers to the following questions about a patient are "yes," 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)?