Disabled Persons Parking Scheme – Application

PRIVACY STATEMENT

The personal information requested on this form is being collected by council for the purpose of issuing an individual disabled persons parking permit, in accordance with the Road Safety (Road Rules) Regulations (Vic) 1999 and associated code. The personal information will be used solely by council for that primary purpose or directly related purposes. Council may disclose this information to other municipal councils for the purpose of confirming the existence of a valid disabled persons parking permit issued by the City of Ballarat. If this information is not collected council may not issue a disabled persons parking permit. The applicant understands that the personal information provided is for the purpose of issuing a disabled persons parking permit and that he or she may apply to council for access to and/or amendment of the information. Requests for access and or correction should be made to council's privacy officer.

This form has two parts to be completed.

- **Part A must be completed by the applicant (the person with the disability) or the applicant's agent.** If filled in by an agent, please ensure all information relates to the applicant only (eg, If the applicant cannot drive please answer 'Passenger Only' and do not provide a Licence No)

- **Part B must be completed by a Medical Practitioner, Specialist Medical Practitioner** or Clinical Psychologist as nominated by the applicant. Please note you do not need to go to your own regular practitioner, provided the practitioner is providing accurate information.

A $6.00 fee applies to all permits

Note: A $6 fee will be charged if you require a replacement permit

Please allow between 2-3 weeks for the assessment and posting of any relevant communications (including permit if successful) by Council. If you have not heard from Council within the specified timeframe you may contact the City of Ballarat during business hours on (03) 5320 5500.

Postal Address PO BOX 655, Ballarat, VIC 3353
Telephone 5320 5500 | Fax 53334061
National Relay Service (hearing or speech impairment) 1300 555 727
or TTY/voice calls 133 677
Email: ballcity@ballarat.vic.gov.au **Website www.ballarat.vic.gov.au**

To use a telephone interpreter T 131 450

Permit No:_____

Is the application being filled in by the applicant's agent? No ☐ Yes ☐

Part A — Disabled Applicant's Details Please use BLOCK LETTERS

$6.00 Fee

Surname:			Date of Birth
Given Names:			
Residential Address of Applicant.	**(must be within City of Ballarat)**		
Postal Address for Permit if different from above:			
Contact Details:	**Landline:**	**Mobile**:	
	Email:		
If Driver/Passenger, please complete these details:	**Driver Licence Number:**	**Expiry Date:**	
Is the Permit for a: (please circle one)	**Driver/Passenger**	**Passenger**	**Temporary**

Declaration by Applicant

I make this declaration in the firm belief that all the information provided on this form is, to the best of my knowledge, true and correct and I am aware that false declarations may be punishable by law. I will fully comply with the 'Conditions of Use' for the Permit. If my circumstances change in anyway likely to affect my eligibility for the permit, I agree to notify the issuing authority within fourteen (14) days. I further agree that the permit remains the property of the issuing Council and will be returned within seven (7) days of notification of such return being required. **The applicant's agent may sign and take full legal responsibility on the applicant's behalf.**

Name of Applicant:	
Applicant's Signature:	
Date:	

Office Use Only

Issue Date:	*Expiry Date:*	*CSO:*	***BLUE OR GREEN***

Applicant's Agent Authority

Name of Agent: _____

Address of Agent: _____

Agent's Phone Number: _____

Agent's Signature: _____

I _____ give the City of Ballarat authority to speak to the above agent to collect any further information required in order to process my disabled permit application. **Please note ONLY the applicant may sign this declaration.** If the applicant is unable to sign, please provide legal authority to act on behalf of the applicant.

_____

Applicant's Signature

Written Authority by Applicant/Applicant's Authorised Agent

(Note: This authority is to be given for the Medical Practitioner, Specialist Medical Practitioner or Clinical Psychologist to fill in this form with relevant information regarding the applicant's medical condition for the assessment of applicant's eligibility.)

Name of Practitioner: _____

Address of Practitioner: _____

I hereby authorise you to complete my application for a disabled Person's Parking Permit and to forward it to the City of Ballarat.
I further authorise you to provide additional medical information or opinion relevant to the consideration or any reconsideration of my application as may be reasonably requested by the authorised Council officer.

_____

Name of Applicant or Agent in Block Letters

_____ _____

Applicant's or Agent's Signature Date

Part B — Statement for completion by a Medical Practitioner, Specialist Medical Practitioner or Clinical Psychologists

Please use BLOCK LETTERS

Please note: The information on this form will be used by Council staff to determine the eligibility of your patient for a Disabled Persons' Parking Permit. A permit will not be issued unless all details on the application are completed.

1. What is your patient's disability?

2. Is the significant disability permanent? (please circle) **YES** (if YES a response is required for Q5-15) **NO**

3. Is the significant disability likely to last less than six months? (please circle) **YES** **NO**

4. Based on your assessment of the best case scenario for your patient's recovery how long do you anticipate the patient will be affected by the disability?
Patient will require a medical certificate after 6 months of the issue date of the temporary permit if it is likely that it will be required for more than 6 months.

_____

PLEASE ANSWER ALL QUESTIONS

Criterion 1:

5. Has their ability to walk been significantly restricted? ☐ Yes ☐ No

6. Does your patient require additional space to access his/her vehicle? ☐ Yes ☐ No

Criterion 2:

7. Does your patient's disability require him/her to continually use an appliance for support to aid his/her mobility? ☐ Yes ☐ No

8. What appliance does your patient use as an aid? _____

9. Is the mobility aid considered a complex walking aid? ☐ Yes ☐ No
A complex walking aid is defined as an aid which has more than one contact point with the ground. Walking sticks (even when multi-pronged) are NOT considered to be complex walking aids.

10. Does the aid prevent your patient from accessing their vehicle in an ordinary parking bay? ☐ Yes ☐ No

Criterion 3:

11. Does your patient have an acute or chronic illness which may affect their health in the immediate or long term should they need to walk a long distance? ☐ Yes ☐ No

12. Does the disability affect their capacity to walk to such an extent that it may become severely injurious (as opposed to inconvenient) to their health? ☐ Yes ☐ No

Criterion 4:

13. Does your patient's disability result in extreme danger to themselves or others in a public place without the continuous attendance of a caregiver? ☐ Yes ☐ No

14. Does the patient have an acute or chronic illness OR an intellectual disability whereby without continuous attendance by a caregiver, they may be an extreme danger to themselves or others in a public place? ☐ Yes ☐ No

Criterion 5:

15. Does your patient's disability affect their capacity to walk distances, such that they require rest breaks? ☐ Yes ☐ No

Declaration by Medical Practitioner, Specialist Medical Practitioner or Clinical Psychologist – please see over page.

Declaration by Medical Practitioner, Specialist Medical Practitioner or Clinical Psychologist

I make this declaration in the firm belief that all the information provided on this form is, to the best of my knowledge, true and correct and I am aware that false declarations may be punishable by law.

In block letters:

Name of Medical Practitioner, Specialist Medical Practitioner or Clinical Psychologist

Signature of Medical Practitioner, Specialist Medical Practitioner or Clinical Psychologist	Date:

Qualifications:	**Telephone Number:**

Address:

An appropriate charge for completion of this application and any necessary examination is to be borne by the applicant.

Once completed, please return this form to:
City of Ballarat
25 Armstrong Street South
Ballarat
Postal Address: PO BOX 655, Ballarat, VIC 3353
Website: www.ballarat.vic.gov.au

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