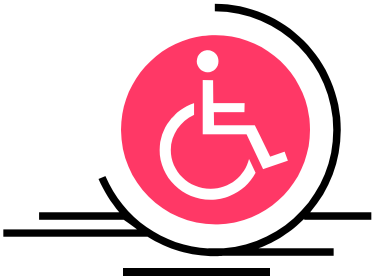
ACCESSIBILITY PARKING PERMIT APPLICATION



Park Mall

Seniors Advocacy Service
#4 – 155 Malcolm Drive, West

Quesnel, BC V2J 3K2
250-992-9330
seniorsadvocate@gmail.com

Hours: Tues & Thurs (11-1pm)

Part A: To be completed by Applicant:

Last Name:	First Name:	
Mailing Address:		
City:	Province:	Postal Code:
Telephone:	Date of Birth:	

Part B: Conditions for Parking Permit Holders:

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 the physician (for maximum one year).

It is the applicant's responsibility to ensure that his/her physician (only) has completed PART D (on the back of this form). The applicant is responsible for ensuring this form is completed and for any charges made for its completion. By submission of this signed form I agree to be responsible for the appropriate use of the permit and understand that it is for my use only.

I understand that Seniors Advocacy Service (SAS) needs to collect certain information about me, and to use and disclose that information for certain purposes. Specifically, I understand that SAS collects personal information (including my name, home address, telephone number, email address and other necessary contact information) and medical information (including the nature of my mobility disability) in order to permit SAS to determine my eligibility for a disabled parking permit and to administer my parking permit . Additionally, I understand that SAS may contact my medical doctor to verify the nature of my disability and my eligibility for a permit. Further, I understand that some personal information collected by SAS may be used to enforce disabled parking within British Columbia. For example, I understand that SAS may disclose my age, gender, reported use of a mobility aid, and whether or not my impairment is of a visible or non-visible nature to an enforcement officer in order to verify that the permit is not being used by someone other than me, the permit holder.

My signature on this form constitutes my consent to the collection, use and disclosure of information by SAS for the purposes described above, and for the disclosure by my medical doctor for the release of medical information to SAS for the purposes described above. I understand that I may withdraw or change my consent at any time, in respect of my personal information and in respect of any of the purposes described above by contacting Seniors Advocacy Service @ 250-992-9330.

_____|_____

Signature of Applicant or Power of Attorney **Date**
(POA document needs to be attached)

Part C: Payment – cash or cheque only to be made out to "Seniors Advocacy Service"

Processing Fee is $26.00
Cash _____ Cheque # _____
Financial assistance may be available with written request submitted to our office.

Part D: To be Completed by a Medical Doctor Authorized to Practice in BC -
PLEASE PRINT

Applicant's Name (same as in Part A):

Give Medical Name of Disabling Condition:

How does this impair mobility:

___ * applicant requires use of mobility aid – what is it ? _____
___ * applicant has disability that affects mobility and the ability to walk
___ * applicant can not walk 100 meters without risk to health and safety
___ * other, please explain_____
_____

Prognosis: This patient is experiencing a mobility impairment which is: **(check one only)**

___ * Permanent

___ * Subject to change, requires medical reassessment in three (3) years

___ * Temporary (**1 month to 1 year**, please give date to expire _____)

Physician's Certification:
For the above reasons, it is my opinion that the patient has a mobility impairment that poses a risk to their health. I hereby certify that, to my knowledge, the above information is true and correct.

_____ _____ |_____|_____
Signature of Physician **Phone Number** **MSP #** **Date**

Physician Office Address Stamp: this MUST be stamped before we can issue permit.