SASKATCHEWAN Abilities COUNCIL

Parking Program for People with Disabilities

Send completed application to the Saskatchewan Abilities Council, 2310 Louise Avenue, Saskatoon, SK, S7J 2C7, or your nearest branch. **Incomplete/illegible applications will be returned.**

SECTION I APPLICANT INFORMATION

Completed by the Applicant/Parent or Guardian. Check <u>one</u> of the following:

☐ Applying for the first time ☐ Applying for renewal of existing permit ☐ Replacing lost permit ☐ Replacing stolen permit ☐ Replacing damaged permit
DAMAGED PERMITS MUST BE RETURNED BEFORE REPLACEMENT WILL BE ISSUED

PLEASE PRINT CLEARLY

Current/Existing Permit Number (if applicable): _____

Surname: _____ First Name: _____

Address: _____ | _____ | _____
Street Number & Name, Box Number | City/Town | Postal Code

Date of Birth: ____/____/____ (Day Month Year) Daytime Phone Number: _____

I, the applicant, acknowledge that:

- I am applying for a parking permit and the information provided on this application is true and correct.
- The parking permit will only be used when the applicant is present. Any misuse of a parking permit will result in the permit being cancelled and the refusal to issue a parking permit in the future.
- I am responsible for any costs related to completing this application.
- If applying for a replacment of a lost or stolen permit, I declare the permit is unavailable for return.
- For audit purposes the information may be shared with SGI.

_____ _____
Signature of Applicant or Parent/Guardian Date

<u>NOTE:</u>

- All information must be completed for processing. Medical information must be current within 3 months of completion of the application.

SASKATCHEWAN ABILITIES COUNCIL OFFICE USE ONLY

Date Application Received: _____ Permanent: _____ Temporary Expiry Date: _____

☐ Approved ☐ Not Approved. If not approved, specify reason: _____

Authorized by: _____ Date: _____ Branch: _____

SECTION 2 MEDICAL INFORMATION **Applicant's Name:** _____

Completed by a physician, occupational therapist, physical therapist or chiropractor. **PLEASE PRINT CLEARLY**

Medical name(s) of disabling condition(s) _____

In layman terms, please describe how this condition impairs the applicant's mobility: _____

Check one of the following:

☐ Short term disability where the applicant is unable to walk more than 50 metres (164 feet) but where the nature of the condition is temporary (example: broken leg). Specify estimated length of the condition in number of months (1 - 12 months maximum).
_____ Months

☐ Disability where the applicant is unable to walk more than 50 metres (164 feet) but where the disability may improve within the next 3 years (example: improvement may result due to therapy, surgery, treatment). The applicant will be required to re-apply in 3 years to determine their eligibility for a parking permit.

☐ Permanent disability where the applicant is unable to walk more than 50 metres (164 feet) and the disability is of a permanent nature and will not improve within the next 3 years. The applicant will be able to self-declare in 3 years to renew their permit and will not require verification from a medical professional. Qualification for a permanent parking permit is where:

- ☐ The applicant requires the use of a wheelchair to travel any distance.
- ☐ The applicant requires a mechanical aid to travel any distance such as a scooter, crutches, walker, lower limb prosthetic device or similar assistive device. The mechanical aid required is:
  _____
- ☐ The applicant has a permanent disability which is not visible such as chronic obstructive pulmonary disease (COPD), cardiovascular disease, or other permanent condition whereby walking a distance of 50 metres (164 feet) or would pose a further risk or endanger their health. Specify risk to health:
  _____

Note: As the authorizing medical professional, you are verifying the applicant has a physical disability that will pose a risk to their health by walking a specified distance. Should there be misuse or abuse of the privileges associated with the issuance of this permit, 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.

Medical Professional's Name & Address (Print or use office address stamp)

Full Name:	Telephone Number:	Medical Office Stamp
Address:	Fax Number:	
City/Town:	Postal Code:	

Professional Designation: ☐ Physician ☐ Occupational Therapist ☐ Physical Therapist ☐ Chiropractor

Certification: It is my opinion that the applicant is eligible for a parking permit under the criteria described above.

_____ _____
Signature of Medical Professional Date