



October 2010

# DISABLED PARKING PERMIT APPLICATION FORM

**HOURS 9:30 AM - 4:30 PM**  
**MONDAY - FRIDAY - Cost: \$18.00**

**We accept payment by cash & debit cards (in person only) credit cards, cheque or money order. (payable to People In Motion)**



182 B Tranquille Road, Kamloops, BC V2B 3G1  
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 Toll Free: 1-877-414-4241  
 information@peopleinmotion.org;  
 www.peopleinmotion.org



Office Use Only

Permit No. \_\_\_\_\_

Payment Type: \_\_\_\_\_

Date Issued: \_\_\_\_\_

Expiry Date: \_\_\_\_\_

Data Entry Date: \_\_\_\_\_

## PART A TO BE COMPLETED BY THE APPLICANT (Please Print)

APPLICANT'S FIRST NAME(S)				FAMILY OR LAST NAME			
MAILING ADDRESS (Apt. No., P.O. Box or RR #)				(Number & Street)		EMAIL ADDRESS	
CITY		PROVINCE BC		POSTAL CODE		TELEPHONE NUMBER (    )	
DATE OF BIRTH YYYY	MM	DD	<input type="checkbox"/> FEMALE		<input type="checkbox"/> MALE		

## PART B CONDITIONS FOR PARKING PERMIT HOLDERS

Only one permit per applicant will be issued.  
 The applicant is responsible for ensuring the form is fully completed and for any charges owed 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.  
 Furthermore, I understand that People In Motion needs to collect certain personal information about me and to use and disclose it for certain purposes.  
 Specifically those purposes are:

1. to determine my eligibility for a disabled parking permit (which can include contacting my Physician)
2. to administer my disabled parking permit (i.e. contacting me re renewal)
3. to support law enforcement of disabled parking (i.e. verifying the permit is not being used by someone other than me, the permit holder)

I understand that all information will be collected, used and disclosed in a manner consistent with People In Motion's Privacy Policy.  
 My signature on this form also constitutes my consent for the collection, use and disclosure of my personal information by People In Motion for the purposes described above.

\_\_\_\_\_  
**SIGNATURE or MARK (X) OF APPLICANT or POWER OF ATTORNEY or LEGAL GUARDIAN      DATE**  
**NOTE Power of Attorney or Legal Guardian should only sign if applicant cannot be responsible for a legal permit.**

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

FIRST NAME(S)				FAMILY OR LAST NAME			
MAILING ADDRESS (Apt. No., P.O. Box or RR #)				(Number & Street)			
CITY		PROVINCE		POSTAL CODE		TELEPHONE NUMBER (    )	
RELATIONSHIP TO APPLICANT							

## PART C - PAYMENT (PLEASE DO NOT SEND CASH IN THE MAIL)

PROCESSING FEE IS \$18.00 ENCLOSED - PAYABLE TO 'PEOPLE IN MOTION'  
 My donation of \$ \_\_\_\_\_ enclosed (Donor's of \$10 or more will receive a charitable tax receipt).  
 METHOD OF PAYMENT    CHEQUE \_\_\_    MONEY ORDER \_\_\_    VISA \_\_\_    MASTERCARD \_\_\_

Card Number: \_\_\_\_\_      Expiry Date \_\_\_\_\_  
MM / YY

Total Amount Authorizing for donation & permit is \$ \_\_\_\_\_      ► \_\_\_\_\_  
SIGNATURE FOR CREDIT CARD PAYMENT

**PLEASE HAVE YOUR PHYSICIAN COMPLETE PART D on the REVERSE**

**PART D TO BE COMPLETED BY A MEDICAL DOCTOR AUTHORIZED TO PRACTICE IN BC (Please print)**

**APPLICANT'S NAME** (Should be the same as applicant in Part A - see reverse)

**GIVE MEDICAL NAME OF DISABLING CONDITION(S)**

**HOW DOES THIS IMPAIR MOBILITY? (Please check one)**

- Applicant requires the use of a mobility aid in order to travel any distance
- Applicant has a disability that affects mobility and the ability to walk specifically
- 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 (permit must be renewed every three years)
- TEMPORARY Estimated length of the condition in number of months (Max 12 Months) \_\_\_\_\_

**Temporary Permit Holders need to reapply should they continue to need a permit.**

**PHYSICIAN'S CERTIFICATION:** for the above reasons, it is my opinion that the patient should be eligible for a disabled person's parking permit. I hereby certify that to my knowledge, the above information is true and correct.

SIGNATURE OF THE PHYSICIAN

DATE

NOTE: *Signature stamps will not be accepted*

PHYSICIAN'S NAME (Please Print)

MSP NUMBER

MAILING ADDRESS (Apt. No., P.O. Box or RR #) (Number & Street)

ADDRESS STAMP

CITY PROVINCE POSTAL CODE

TELEPHONE NUMBER

( )

**PART E STATISTICAL INFORMATION (this data will help us to improve accessibility in BC):**

PLEASE INDICATE MOBILITY AID(S) USED:

- Walking aid (cane, walker, crutches, etc.)
- Scooter
- Not Applicable
- Wheelchair (manual or motorized)
- Other

YOUR PERMIT WILL BE USED IN A VEHICLE WITH A (check all that apply)

- Side lift
- Rear lift
- Raised roof
- Car
- Truck
- None of these

Are you the  Driver  Passenger

I REQUIRE PARKING THAT IS:  Standard sized  Extra Wide  Extra long