People In Motion
Creating a better tomorrow for People with disabilities.

August 2016

DISABLED PARKING PERMIT APPLICATION

HOURS 9:30 AM - 4:30 PM
MONDAY - FRIDAY

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	☐ FEMALE	☐ 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)

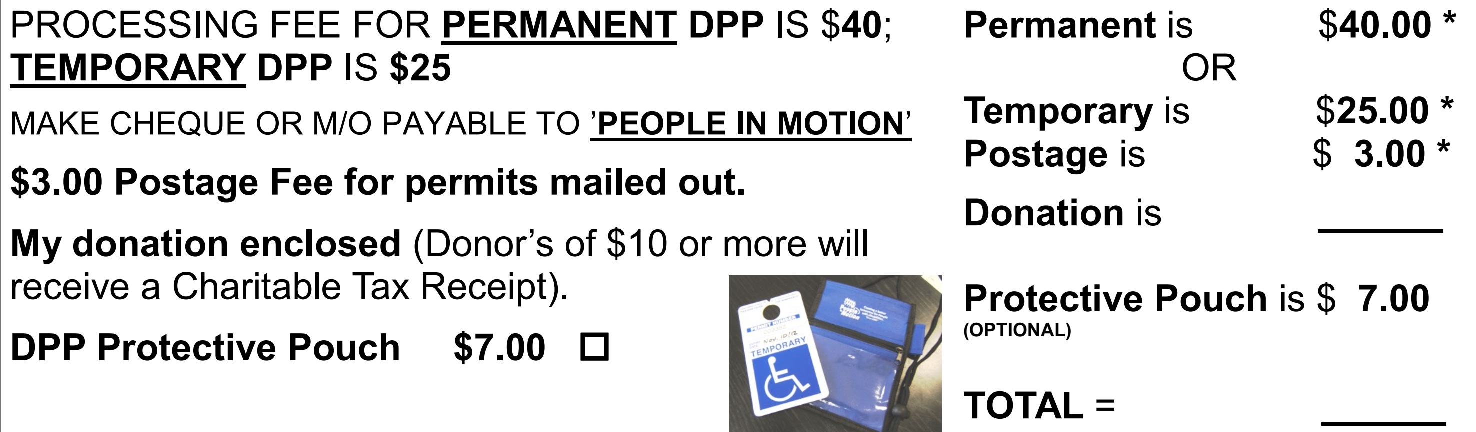
I understand that all information will be collected, used and disclosed in a manner consistent with People In Motion's Privacy Policy.
My signature on this form also constitutes my consent for the collection, use and disclosure of my personal information by People In Motion for the purposes described 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. Please fill out Part E on the back if you have signed for the applicant.

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

(*) Mandatory



PROCESSING FEE FOR **PERMANENT DPP** IS $**40**; **TEMPORARY DPP** IS **$25**

MAKE CHEQUE OR M/O PAYABLE TO '**PEOPLE IN MOTION**'

$3.00 Postage Fee for permits mailed out.

My donation enclosed (Donor's of $10 or more will receive a Charitable Tax Receipt).

DPP Protective Pouch $7.00 ☐

Permanent is **$40.00 ***
OR
Temporary is **$25.00 ***
Postage is **$ 3.00 ***
Donation is ______
Protective Pouch is **$ 7.00**
(OPTIONAL)
TOTAL = ______

METHOD OF PAYMENT CHEQUE ___ MONEY ORDER ___ VISA ___ MASTERCARD ___

Card Number: | | | | **Expiry Date** ______ MM / YY ► ________________ 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 NOTE: *Signature stamps will not be accepted*	DATE

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 Power of Attorney and Legal Guardian information - Please Print

FIRST NAME(S)		FAMILY OR LAST NAME	
MAILING ADDRESS (Apt. No., P.O. Box or RR #) (Number & Street)			
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER (250)
RELATIONSHIP TO APPLICANT			