BC Parking Permit Program for Persons with Disabilities
Application for Parking Permit

Victoria Disability Resource Centre
Promoting a new perspective on disability

817 A Fort Street, Victoria, B.C. V8W 1H6
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PART A: TO BE COMPLETED BY THE APPLICANT (please print clearly)

APPLICANT'S FIRST NAME(S)		FAMILY OR LAST NAME	
MAILING ADDRESS		E-MAIL ADDRESS	
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER ( )

DATE OF BIRTH ______ YEAR ______ MONTH ______ DAY ☐ FEMALE ☐ MALE

Have you applied for a VDRC parking permit before? ☐ YES ☐ NO If yes, Permit #

PART B: CONDITIONS FOR PARKING PERMIT HOLDERS

- It is the applicant's responsibility to ensure that his/her physician 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. (Any fees paid to complete the form are in addition to the cost of the permit.) All applications are subject to eligibility criteria.
- ***ONLY ONE PERMIT PER APPLICANT:*** Permits issued for permanent disabilities must be renewed every three years. Temporary permits will be valid for a period of time as determined by your physician (maximum one year). All personal information will remain strictly confidential.
- Return the original of this form to the VDRC. A permit cannot be issued without the original signatures being on file with us.
- I agree to be responsible for the appropriate use of the permit. I understand that only I am permitted to use this permit. I understand the information above and hereby authorize the release of any information requested with respect to this application.

______________________________ **DATE** ______________

SIGNATURE OR MARK (X) OF APPLICANT OR POWER OF ATTORNEY OR LEGAL GUARDIAN*

*Power of attorney/legal guardian to sign only if applicant cannot be responsible for a legal permit

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

FIRST NAME(S)	FAMILY OR LAST NAME
MAILING ADDRESS	
RELATIONSHIP TO APPLICANT	

SHADED AREA IS FOR OFFICE USE ONLY

LAST NAME & INIT:		**PERMIT #:**	
ISSUE DATE:		**EXPIRES:**	
ISSUED BY:		☐ **Permanent**	☐ **Temporary**

PART C: PAYMENT (to be completed only if you submit this application by mail)

PROCESSING FEE

$25.00 ☐ if paying in person or **$27.00** ☐ if mailing a cheque or credit card number

DONATIONS ARE GRATEFULLY ACCEPTED $________

Donations of $20 or more receive tax receipt

PLEASE MAKE CHEQUES PAYABLE TO:
Victoria Disability Resource Centre

Donations are gratefully accepted and contribute significantly towards providing services, skills training and information to persons with disabilities to enable them to lead more independent lives. We thank you for any donation you may contribute.

METHOD:	☐ Credit Card	☐ VISA	EXPIRY DATE
☐ Cash	☐ Debit Card	☐ M/C ______________________________	______/______
☐ Cheque	☐ Money Order	CREDIT CARD NUMBER	Month / Year

I authorize $__________________ Signature________________________ Date__________________________

PART D: TO BE COMPLETED IN FULL BY A MEDICAL DOCTOR

Please note: As the authorizing medical doctor you are verifying this applicant meets the eligibility criteria to have a parking permit issued. Should there be misuse or abuse of the privileges associated with the permit, you may be asked to verify the applicant's disability. The applicant is responsible for any costs incurred by the completion of this application.

Applicant eligibility (please check one)

- ☐ Applicant has a disability that limits mobility
- ☐ Applicant cannot walk 100 metres without risk to health
- ☐ Applicant requires the use of a mobility aid such as a wheelchair, scooter, walker or crutches
- ☐ Other (please specify) ____________________
  ____

APPLICANT'S NAME (SHOULD BE THE SAME AS APPLICANT IN PART A - SEE REVERSE)

PROGNOSIS (please note: this section must be completed)

This patient is experiencing a mobility impairment that is (**CHECK ONE ONLY**):

☐ **PERMANENT** (Permit must be renewed every 3 years)

☐ **TEMPORARY** (MAXIMUM of 1 year)

If TEMPORARY, please give the date by which the disability is likely to cease*:

MONTH: ____________________ YEAR: 20_____.

*PLEASE NOTE: Should a temporary permit holder require a longer period of recovery, he/she will have to reapply for a permit after the date specified.

CERTIFICATION – MUST BE COMPLETED IN FULL

For the above reasons, it is my opinion that the applicant has a mobility impairment and is eligible for a disabled parking permit. I hereby certify that to my knowledge, the above information is true and correct.

____ ____________________________

SIGNATURE OF THE MEDICAL DOCTOR DATE

Original signature required

PHYSICIAN'S NAME (Please Print)		**MSP #**	**ADDRESS STAMP**
ADDRESS			
CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER