Independent Living
Vernon
Promoting a new perspective on disability

APPLICATION FORM

MONDAY TO THURSDAY
8:30 – 4:00PM
CLOSED NOON – 12:30

CLOSED FRIDAYS

PARKING PERMIT PROGRAM
FOR PEOPLE WITH DISABILITIES
107-3402 27TH AVE
VERNON, BC V1T 1S1
(In the People Place)

TEL: 250 545-9292
FAX: 250 545-9226
TOLL FREE:1-877-288-1088

PART A: TO BE COMPLETED BY THE APPLICANT (please print)

APPLICANT'S FIRST NAME	FAMILY OR LAST NAME	
MAILING ADDRESS	CITY	
Male or Female (Please Circle) DATE OF BIRTH: Month: ___ Day:_____ Year: _____	POSTAL CODE	PHONE
	Email Address:_____	

PART B: CONDITIONS FOR PARKING PERMIT HOLDERS

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 Doctor (maximum one year). All personal information will remain strictly confidential.

It is the applicant who is responsible for ensuring this form is completed and for any charges made for its completion.

I agree to be responsible for the appropriate use of this permit. I understand **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

x_____ _____
Signature of Applicant or Power of Attorney DATE
Or legal Guardian

PART C: PAYMENT PROCESSING FEE IS: $22.00. NEW PRICE STARTING JANUARY 2019

CASH CHEQUE MONEY ORDER VISA MASTERCARD

Card Number:_____ Expiry Date: _____

Total Amount Authorizing for $_____ _____
Signature for Credit Card Payment

PLEASE MAKE ALL CHEQUES PAYABLE TO INDEPENDENT LIVING VERNON

TYPE OF PERMIT (**Office use only**) PERMIT #_____

PERM ☐ TEMP. ☐ ORGANIZATION ☐ EXPIRES:_____

PART D: TO BE COMPLETED BY A MEDICAL PROFESSIONAL (please print)

Certifying medial professional must complete this section. Please note: As the authorizing medical professional, you are verifying the applicant has a mobility disability that will pose a risk to their health by walking 100 meters. Your authorization entitles them for special parking identification. Should there be misuse or abuse of the privileges associated with the issuance of this special identification, you may be requested to verify the applicant's disability. The applicant is responsible for any or all costs incurred in the completion of this application.

APPLICANT'S NAME **(SHOULD BE THE SAME AS ON THE FRONT)**

GIVE MEDICAL NAME OF **MOBILITY DISABILITY**:

CANNOT WALK A DISTANCE GREATER THAN 100 METRES ☐ LEGALLY BLIND ☐

PROGNOSIS

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

☐ **PERMANENT** (MUST BE RENEWED EVERY 3 YRS)

☐ **TEMPORARY(1yr or less)** ☐ **ORGANIZATION**

If temporary, please give the date by which Parking Permit will no longer needed

Please Note: Should a temporary permit holder require a longer period of recovery, they will have to *REAPPLY* for a permit after the date specified

MONTH: _____ YEAR_____ **MAXIMUM 1 YEAR**

CERTIFICATION

For the above reasons, it is my opinion that the patient has a mobility impairment that poses a risk to their health by walking 100 metres. I hereby certify that to my knowledge, the above information is true.

_____ _____

SIGNATURE OF THE MEDICAL DOCTOR DATE

Physician's Name (please print)

_____

MSP # _____

ADDRESS STAMP