APPLICATION FORM

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

Monday - Friday
8:30 am to 3:30

Phone: 250 545-9292
Fax: 250 545-9226
Toll free :1-877-288-1088
Email: permits@ilvernon.ca

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

APPLICANT'S FIRST NAME	FAMILY OR LAST NAME	
MAILING ADDRESS	CITY	
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.

CASH CHEQUE/MONEY ORDER Visa, American Express & MC

Card Number:_____ Expiry Date: _____
V-Code : _____

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.

I am recommending the following patient for a Independent Living Vernon Parking Permit::

Does the medical or Mobility condition meet the following criteria? (Please check all that apply)

☐ Applicant has a disability that affects there mobility and the ability to walk specifically

☐ Applicant can NOT walk 100 meters with our risk to their health

☐ Applicant requires the use of a mobility aid to travel any distance

PROGNOSIS

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

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

☐ **TEMPORARY(1yr or less)**

☐ 3 months ☐ 6 months ☐ 1 yr

☐ **ORGANIZATION**

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

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)

_____

ADDRESS STAMP

MSP # _____