**SECTION 2 MEDICAL INFORMATION** **Applicant's Name:** ___________________________________

**Completed by a Physician, Occupational Therapist, Physical Therapist, Nurse Practitioner or Chiropractor.**

**PLEASE PRINT CLEARLY**

***PROGRAM ELIGIBILITY:*** **Persons unable to walk unassisted for more than 50 metres (164 feet) without great difficulty or danger to their health and safety.**

1. Medical name(s) of disabling condition(s): ____________________________________________________________
   ____________________________________________________________________________________________

2. In layman terms, please describe how this condition impairs the applicant's mobility: _________________________
   ____________________________________________________________________________________________
   ____________________________________________________________________________________________

3. Check **one** of the following durations:

   ☐ **Short term** disability where the nature of the applicant's condition is temporary (example: broken leg). **Specify estimated length of the condition in number of months: ______ (1-12 months maximum).**

   ☐ **Long term** disability where the nature of the applicant's condition may improve over the next 3 years (example: improvement may result due to therapy, surgery, treatment). The applicant will be required to re-apply should an extension be required.

   ☐ **Permanent** disability where the nature of the applicant's condition is permanent and will not improve. The applicant will be able to self-declare to renew their permit and will not require verification from a healthcare professional.

4. The applicant has a disability which is not visible such as chronic obstructive pulmonary disease, cardiovascular disease, or other condition, whereby walking a distance of 50 metres (164 feet) would pose a further risk or endanger their health. Specify risk to health: ________________________________________________________________
   ____________________________________________________________________________________________

5. The applicant uses a mechanical aid to travel any distance. Check one of the following (*if applicable)*:
   ☐Wheelchair ☐Scooter ☐Crutches ☐Walker ☐Cane ☐Lower Limb Prosthetic Device ☐Other: ___________

**Note:** As the authorizing healthcare professional, you are verifying the applicant has a physical disability that will pose a risk to their health by walking a specified distance. Should there be misuse or abuse of the privileges associated with the issuance of this permit, you may be requested to verify the applicant's disability. The applicant is responsible for any and all costs incurred in the completion of this application.

**Healthcare Professional's Name and Address** (Print or use office address stamp)

| Full Name: | Telephone Number: | Medical Office Stamp |
|---|---|---|
| Address: | Fax Number: | |
| City/Town: | Postal Code: | |

**Professional Designation:**

☐Physician ☐Occupational Therapist ☐Physical Therapist ☐Nurse Practitioner ☐Chiropractor

**Certification:** It is my opinion that the applicant is eligible for a parking permit under the criteria described above.

______________________________________ ______________________________________
Signature of Healthcare Professional Date