SaskAbilities Accessible Parking Program

Mail completed application to SaskAbilities, 2310 Louise Avenue, Saskatoon, SK, S7J 2C7, or bring it into your nearest Special Needs Equipment depot. **Faxed, photocopied, or emailed applications will not be accepted.**

SECTION 1 APPLICANT INFORMATION (Applicant is the individual with the mobility impairment.)

Check **one** of the following:

- □ Applying for the first time.
- □ Applying for the renewal of existing short term or long term permit.
- □ Applying for the renewal of existing permanent permit. I self-declare that my medical condition has not improved and I still require a parking permit.
- □ Applying for the replacement of a permit due to: ☐Lost ☐Stolen ☐Damaged *(Damaged permit must be returned before replacement will be issued.)*

PLEASE PRINT CLEARLY – Incomplete/illegible applications will not be processed.

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ | _____ | _____
City/Town Postal Code

Date of Birth: _____/_____/_____
Day Month Year

Daytime Phone Number: _____

Email Address (optional): _____

I, the applicant, acknowledge that:

- I am applying for a parking permit and the information provided on this application is true and correct.
- The parking permit will only be used when the applicant is entering or exiting the vehicle. Any misuse of a parking permit will result in the permit being cancelled and the refusal to issue a parking permit in the future.
- The medical information must be completed by one of the designated healthcare professionals. Any unauthorized changes of the medical information will nullify the application form.
- I am responsible for any costs related to completing this application.
- If applying for a replacement of a lost or stolen permit, I declare the permit is unavailable for return.
- For audit purposes, the information may be shared with SGI.
- I am responsible for advising SaskAbilities of any mailing address or email address changes.

_____ _____
Signature of Applicant, Parent/Guardian, or Power of Attorney Date

NOTE:

All information must be completed for processing. Once the healthcare professional completes the application, it must be submitted to SaskAbilities within 3 months or a new application will be required.

METHOD OF PAYMENT – Permit Fee: $10.00. Permit Fee is non-refundable.

Cheque or Money Order made payable to SaskAbilities.

All NSF cheques will be subject to an additional $15.00 administration fee.

☐Cheque ☐Money Order ☐Interac ☐Cash

☐Visa ☐MasterCard Name on Credit Card: _____

Credit Card Number: _____ Credit Card Expiry Date: _____/_____

SASKABILITIES OFFICE USE ONLY

Permit Number: _____ Permit Type _____ Expiry Date: _____

☐Approved ☐Not Approved _____

Authorized by: _____ Date: _____ Branch: _____

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 requires 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