SASKATCHEWAN Abilities COUNCIL

Parking Program for People with Disabilities

Send completed application to the Saskatchewan Abilities Council, 2310 Louise Avenue, Saskatoon, SK, S7J 2C7, or your nearest branch. **Faxed or photocopied 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 changed and I still require a parking permit.
- ☐ Applying for the replacement of a: i) lost _____ ii) stolen _____ or iii) damaged permit _____.
  (Damaged permit must be returned before replacement will be issued.)

PLEASE PRINT CLEARLY - Incomplete/illegible applications will be returned.

Surname: _____ First Name: _____ Middle Initial: _____

Address: _____ | _____ | _____
Street Number & Name, Box Number | City/Town | Postal Code

Date of Birth: ____/____/____ (Day / Month / Year) Daytime Phone Number: _____

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 present. Any misuse of a parking permit will result in the permit being cancelled and the refusal to issue a parking permit in the future.
- 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 the Saskatchewan Abilities Council of any address changes.

_____ _____
Signature of Applicant or Parent/Guardian Date

NOTE:
All information must be completed for processing. When the application is completed by the healthcare professional, it must be submitted to the Saskatchewan Abilities Council 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 payable to the Saskatchewan Abilities Council.

Please do not send cash in the mail. *All NSF cheques will be subject to an additional $15.00 administration fee.*

☐ Cheque ☐ Money Order ☐ Interac ☐ Cash

☐ Visa ☐ MasterCard Name on Card: _____

Card Number: _____ Expiry Date: _____/_____

SASKATCHEWAN ABILITIES COUNCIL OFFICE USE ONLY

Permit Number: _____ Permit Type: _____ (ST, LT, P) 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

Medical name(s) of disabling condition(s): _____

In layman terms, please describe how this condition impairs the applicant's mobility: _____

Check one of the following three highlighted durations:

☐ **Short term** disability where the applicant is unable to walk unassisted for more than 50 metres (164 feet) without great difficulty or danger to their health and safety but where the nature of the condition is temporary (example: broken leg). **Specify estimated length of the condition in number of months (1-12 months maximum) _____ Months.**

☐ **Long term** disability where the applicant is unable to walk unassisted for more than 50 metres (164 feet) without great difficulty or danger to their health and safety but where the disability may improve within 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 applicant is unable to walk unassisted for more than 50 metres (164 feet) without great difficulty or danger to their health and safety and the disability is of a permanent nature and will not improve within the next 3 years. The applicant will be able to self-declare to renew their permit and will not require verification from a healthcare professional. To be eligible for a permanent parking permit:

- ☐ The applicant uses a wheelchair to travel any distance.
- ☐ The applicant uses a mechanical aid to travel any distance. The mechanical aid is: (check one)
  - ☐ Scooter ☐ Crutches ☐ Walker ☐ Cane ☐ Lower Limb Prosthetic Device
  - Other - specify: _____
- ☐ The applicant has a permanent disability which is not visible such as chronic obstructive pulmonary disease (COPD), cardiovascular disease, or other permanent condition whereby walking a distance of 50 metres (164 feet) would pose a further risk or endanger their health. **Specify risk to health:** _____

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 & 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 _____