SWAN HILL
Rural City Council

Please return this completed form to:
PO Box 488, Swan Hill VIC 3585 | DX 30166
45 Splatt Street, Swan Hill VIC 3585
68-72 Herbert Street, Robinvale VIC 3549
Tel: 03 5036 2333 | Fax: 03 5036 2340
Email: locallaws@swanhill.vic.gov.au

Disabled Persons Parking Scheme

Application

Section One: To be completed by the applicant (person with the disability) or the applicant's agent.

Applicant details (person with the disability)	Name:		
	Address:		
	Postal address: (if different from above)		
	Date of birth:	Gender: ☐ Male ☐ Female	
	Phone:	Mobile:	
Previous Disabled Parking Permit:	☐ Yes ☐ No	☐ Blue ☐ Green	Permit Number: Expiry:
Parking label is for a:	☐ Driver and/or Passenger (A) please fill in Licence Number & Expiry Date below: Licence Number: ____________ Expiry Date: ________ ☐ Passenger Only (B) ☐ Temporary Permit (T)		

What is your disability?
What appliance do you use as an aid?

Declaration by applicant

I make this declaration in the firm belief that all the information provided on this form is, to the best of my knowledge, true and correct and I am aware that false declarations may be punishable by law. I will full comply with the "Conditions of Use" for the Permit. If my circumstances change in any way likely to affect my eligibility for the permit, I agree to notify the issuing authority within 14 days. I further agree that the permit remains the property of the issuing council and will be returned within seven days of notification of such return being required. The Applicant's agent may sign and take full legal responsibility on the Applicant's behalf.

Applicant's signature (or applicant's agent): ______________________ **Date:** ____________

Office Use Only	Permit Number:	Code:	☐ Blue Permit ☐ Green Permit	Expiry Date:	Officer:

Section Two:	To be completed by a medical practitioner / specialist medical practitioner / clinical psychologist

The information on this form will be used by Council staff to determine the eligibility of your patient for a Disabled Person's Parking Permit. **Permits will not be issued unless all the details are completed.**

Question	Answer
1. What is your patient's disability?	
2. Does your patient's disability require him/her to continually use an appliance for support to aid his/her mobility?	☐ Yes ☐ No
3. Does your patient require additional space to access his/her vehicle due to the disability?	☐ Yes ☐ No
4. Does the use of an aid cause your patient to need additional space to access his/her vehicle?	☐ Yes ☐ No
5. What appliance does your patient use as an aid?	
6. Is the significant disability permanent?	☐ Yes ☐ No
7. If you answered **NO** to question 6, please answer this question: Is this significant disability likely to last less than six months?	☐ Yes ☐ No
8. Does your patient's disability result in extreme danger to themselves or others in a public place without the continuous attendance of a caregiver?	☐ Yes ☐ No
9. Does your patient's disability affect their capacity to walk distances such that they require rest breaks?	☐ Yes ☐ No
10. Is the mobility aid consistent with the applicant's disability?	☐ Yes ☐ No
11. Does the applicant have either an acute or chronic illness in which minimal walking may endanger his/her health acutely or in the long term? If YES, please explain:	☐ Yes ☐ No

Additional supporting information known to you:

Declaration

I make this declaration in the firm belief that all information provided on this form is, to the best of my knowledge, true and correct and I am aware that false declarations may be punishable by law.

Signature of Medical Practitioner/Specialist/Clinical Psychologist:	**Date:**
Name of Medical Practitioner/Specialist/Clinical Psychologist:	**Qualifications:**
Address:	**Phone:**