

ACROD Parking Program Application Form



Important information – to be read by all applicants

Eligibility Criteria

To be eligible for a disability parking permit, you must meet **one** of the following criteria:

- Have a severe mobility impairment where walking more than 50 metres causes the physical condition to deteriorate; and or
- Require the use of a wheelchair, crutches, walking frame or other specific mobility aid.

If you do not meet at least one of the above criteria, you are not eligible for a disability parking permit. For further information, please contact the ACROD Parking Program on 9242 5544.

How to apply

The ACROD Parking Program is administered by National Disability Services WA (NDS WA) under state legislation. All applications must be endorsed by a Doctor or Occupational Therapist. Applications will also be audited by ACROD Parking Program health professionals.

PART A: Must be completed by the applicant.

PART B: Must be completed by your Doctor or Occupational Therapist.

(Note, you may need to book an extended appointment to ensure your Doctor has sufficient time to complete Part B of this form.

Administration Fee

A non-refundable administration fee of **\$16.50** must be submitted with each application. As this fee is **non-refundable** you should carefully consider whether you meet the eligibility criteria before submitting your application. NDS WA is a non-government, not for profit organisation and uses the fee to manage and administer the ACROD Parking Program.

Submitting your application

Send your completed application to:

Post: ACROD PARKING PROGRAM PO Box 1428, OSBORNE PARK DC WA 6916

Email: app@app.org.au **Fax:** 9242 5044

Processing time

Because of the high number of applications we receive, please be patient. Assessment of new applications will take a minimum of ten working days and may take up to one month if additional information is required from your Doctor / Occupational Therapist.

Declined applications

If your application is not successful, information will be provided to you about our appeals process.

More Information

For more information about the ACROD Parking Program, please visit our website www.app.org.au or phone 9242 5544.

Privacy Statement: In accordance with National Privacy Principle (NPP04), information contained in the application form will not be disclosed to any other organisation. However, the ACROD Parking Program may use the general statistics gathered to provide feedback for future planning. General statistical information does not identify any person. You may access your own information by written request. The ACROD Parking Program takes all reasonable steps to protect the information it collects that may identify an individual from misuse; unauthorised access; and disclosure. For more information on your privacy and the Ten Privacy Principles go to: www.privacy.gov.au

PART A – TO BE COMPLETED BY THE APPLICANT

Applicant Details

Title: Mr Mrs Ms Miss Other _____

Sex: Male Female

Surname:	
Given Names:	

Date of Birth:									
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* NB: A residential address must be provided

Street Address:							
Suburb:			P/Code:				

Home Phone:									
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Mobile Phone:									
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Email:	
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Postal address (if different from above)

Postal Address:							
Suburb			P/Code				

Applicant Statement

1. Do you require the use of any mobility aids?

- Yes, please state:**
- Type of mobility aid: _____
 - Frequency of use: _____

No, please state how often your walking is restricted:

2. What is the greatest distance you can walk? _____ metres

3. Describe how your body feels when you walk?

4. What do you do to manage your condition? e.g. type of pain medication, therapy.

5. Recent Medical Reports

Please attach **copies** of any recent medical reports (e.g. radiology) relevant to your mobility in support of this application for an ACROD parking permit. (do not include original documents as these cannot be returned to you)

Reports Attached

Yes

No

6. I confirm that my signature verifies the following:

- The information contained in this form has been endorsed by my Doctor / Occupational Therapist who, in turn, may disclose information about me to assist with my application; and
- I agree that Health Professionals or Service Providers may disclose information about me to the ACROD Parking Program to assist with the assessment of my application; and
- The information in this application is correct to the best of my knowledge.

Signature: _____

Date: _____

Payment Details

Applicants must include a **non-refundable** administration fee of **\$16.50** with the application.

Payment by cheque / money order

Cheques and money orders must be made payable to the ACROD Parking Program.

Payment by credit card

Credit Card Number: _____ - _____ - _____ - _____

Card Expiry Date: _____ / _____
Month Year

Mastercard

Visa

Cardholders Name: _____

Signature: _____ Contact Number: _____

PART B – TO BE COMPLETED BY YOUR DOCTOR OR OCCUPATIONAL THERAPIST

Doctor / Occupational Therapist Statement

1. The applicant:

Has a severe mobility impairment where walking more than 50 metres causes the physical condition to deteriorate; and or

Requires the use of a wheelchair, crutches, walking frame or other specific mobility aid.

2. State the applicant's primary and secondary diagnosis that impacts on their ability to walk:

_____	Date of Diagnosis:

3. Provide objective measurements indicating the severity of the applicants condition (e.g. spirometry, echocardiogram, doppler studies).

4. Indicate the frequency of the applicant's walking restriction:

5. Is surgery being considered for the applicant?

Yes, state type and timeline: _____


No

6. Is the applicants ability to walk likely to improve following treatment, recovery or rehabilitation?

7. What is the expected duration of the treatment / recovery?

Doctor / Occupational Therapist Identification

(please print or stamp these details)

Name:			
Postal Address:			
Suburb:			
Registration No:			
Email:			
Phone:		Fax:	

I certify that I have seen the applicant in a professional capacity and my signature below verifies ALL of the following:

- ✓ The information supplied within this application form is correct to the best of my knowledge;
- ✓ The applicant has a significant mobility impairment;
- ✓ I am not the applicant or an immediate family member of the applicant;
- ✓ I agree to be contacted to verify the information contained in this form; and
- ✓ I understand that it is an offence to verify any false information provided in this application.

Signature: _____ **Date:** _____

A permit will not automatically be granted. All applications are subject to assessment by NDS WA. You may be contacted for further information.

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ACROD Parking Program

T (08) 9242 5544 **F** (08) 9242 5044 **W** www.app.org.au **E** app@app.org.au

