**ACROD Parking Program**

Temporary Permit Extension Form

Part A: Must be completed by the applicant (temporary permit holder)

Part B: Must be completed by your Doctor or Occupational Therapist

**Part A. To be completed by the applicant**

## Applicant Details

ACROD Permit Number:

Date of Birth (dd/mm/yyyy):

Surname:

First Name:

Residential Address:

Suburb:

Postcode:

Postal Address (if different from above):

Suburb:

State:

Postcode:

Phone:

Email:

## Do you require the use of a mobility/medical aid such as a wheelchair, crutches, walking frame or portable oxygen?

* No
* Yes
* If yes, please state type:

## How far can you walk before you stop to rest?

This question must be answered. To help you measure a distance, the width of one car bay generally equals 2.5 metres

Write your answer in metres:

## Please rate these symptoms when you walk (0 being no symptoms, and 10 being extreme symptoms):

## Pain (0 = no pain, 10 = extreme pain)

## Write your answer:

## Breathlessness (0 = normal breathing, 10 = can’t breathe at all / need oxygen)

## Write your answer:

## If there are any additional comments you wish to make, please write them here or attach a separate page.

Write your answer:

## I confirm that my signature verifies the following:

* The information contained in this application is correct to the best of my knowledge.
* The information contained in this form has been endorsed by my Doctor / Occupational Therapist (PART B) who, in turn, may disclose information about me to assist with my application.

## Applicant Signature:

Signature:

Date:

**Part B. To be completed by Doctor / Occupational Therapist**

Eligibility Criteria

Criteria 1: The applicant is unable to walk and always requires the use of a wheelchair; or

Criteria 2: The applicant’s ability to walk is severely restricted by a permanent medical condition or disability; or

Criteria 3: The applicant’s ability to walk is severely restricted by a temporary medical condition or disability; or

Criteria 4: The applicant is legally blind.

Further information on eligibility is available on the “Information for health professionals” webpage (www.acrod.org.au/infohp).

## Please specify the applicant’s diagnosis that impacts on their ability to walk:

Write your answer:

## How long do you anticipate the applicant’s disability or medical condition will continue to severely impact on their ability to walk?

Write your answer in months:

## What is the reason for the applicant’s continued walking restriction? (please tick):

* Further treatment / rehabilitation is required
* Recovering from surgery
* Waiting for surgery
* Other, specify:

## Doctor / Occupational Therapist Identification (please print or stamp these details)

Name:

Street Address

Suburb

Postcode

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;
* I am not the applicant or an immediate family member of the applicant; and
* I agree to be contacted to verify information contained in this form.

Signature:

Date:

**Email your completed application to
acrod@nds.org.au**

**Or post to:
ACROD Parking Program,
PO Box 184 Northbridge WA 6865**

**Telephone:** 08 9242 5544

**Fax:** 08 9242 5044

[ACROD Parking Program website: acrod.org.au](http://acrod.org.au/)