ACROD Parking Program
Temporary Permit Extension Form

Office Use Only

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

1. Applicant Details

ACROD Permit Number:		Date of Birth:	
Surname:			
First Name:			
Postal Address:			
Suburb:		Postcode:	
Phone:			
Email:			

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

☐ No. ☐ Yes. State type_____

3. How far can you walk before you stop to rest? _____ metres

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

4. Please rate these symptoms when you walk.
Please circle the number that applies with 0 being no symptoms, and 10 being extreme symptoms.

Pain										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No pain					*Medium pain*					*Extreme pain*

Breathlessness										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Normal breathing					*Some breathlessness*					*Can't breathe at all / need oxygen*

If there are any additional comments you wish to make, please attach a separate page.

5. 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.

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).

1. **Please specify the applicant's diagnosis that impacts on their ability to walk:**

   _____

   _____

2. **How long do you anticipate the applicant's disability or medical condition will continue to severely impact on their ability to walk?** _____ months

3. **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: _____

4. **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 form to acrod@nds.org.au or post to:
ACROD Parking Program, PO Box 184, Northbridge WA 6865

National Disability Services