

# ACROD Parking Program Temporary Permit Extension Application Form

Office Use Only

Please read the information on the enclosed letter before completing this application.

Part A: Must be completed by the applicant

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:			
Residential Address:			
Suburb:		Postcode:	
Postal Address (if different from above)			
Suburb:		Postcode:	
Phone:			

### 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 and 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. Describe how your body feels when you walk (i.e what are your symptoms?).

\_\_\_\_\_

### 5. Describe how you walk (e.g. speed, balance or how you think you look to others when you walk).

\_\_\_\_\_

### 6. If there are any other comments you wish to make about your walking, please attach a separate page.

### 7. 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.

Further information on eligibility is available by requesting the 'Health Professionals Guide'. Request a copy via [acrod@nds.org.au](mailto:acrod@nds.org.au) or 08 9242 5544.

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

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#### 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:** \_\_\_\_\_

#### Post your completed application to:

ACROD Parking Program, PO Box 184, Northbridge WA 6865

#### ACROD Parking Program

E [acrod@nds.org.au](mailto:acrod@nds.org.au) T 08 9242 5544 F 08 9242 5044 W [www.acrod.org.au](http://www.acrod.org.au)

