

The ACROD Parking Program supports people with a severe walking restriction to access the community.

### Eligibility Criteria

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

- 1** You are unable to walk and **always** require the use of a wheelchair; or
- 2** Your ability to walk is **severely** restricted by a permanent medical condition or disability; or
- 3** Your ability to walk is **severely** restricted by a temporary medical condition or disability.

### How to Apply

**Step 1.** Complete Section 1 of the application form.

**Step 2.** Take your form to your Doctor or Occupational Therapist to complete Section 2.

**Step 3.** Send the completed application form to:



Email: [acrod@nds.org.au](mailto:acrod@nds.org.au)  
OR  
ACROD Parking Program  
PO BOX 184, Northbridge WA 6865

### Assessment of Applications

The ACROD Parking Program assessment team will assess each application against the eligibility criteria. If more information is needed to determine eligibility, the ACROD Parking Program may:

- Contact the applicant (or legal guardian) to ask for additional information.
- Contact the Doctor or Occupational Therapist who completed the application form to ask for additional information.

The ACROD Parking Program receives a high number of applications. Processing your application may take up to 20 working days from the date your application is received. This does not include mailing time.

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

### Privacy Statement

In accordance with Australian Privacy Principles, information contained in the application form will not be disclosed to any organisation other than your Doctor or Occupational Therapist. However, the ACROD Parking Program may use the general statistics for future planning. General statistical information does not identify any person. You may access your own information by written request. ACROD Parking Program takes all reasonable steps to protect the identifying information it collects from misuse, unauthorised access and disclosure. The Applicant recognises and accepts that the ACROD Parking Program must take all reasonable steps to ensure that any party to whom personal information is released is aware and complies with the Australian Privacy Laws. Accordingly, information is to be held and dealt with in accordance with the Australian Privacy Act 1988 and the 13 Privacy Principles set out in the Act. For more information on privacy go to [www.privacy.gov.au](http://www.privacy.gov.au).

# SECTION 1. Applicant Details

Title:  Mr  Mrs  Ms  Miss  Other \_\_\_\_\_

Surname:

First Name:

(as it is on official documentation such as a birth certificate)

Preferred Name (if different):

Date of Birth:   /   /      
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Residential Address:

Suburb:

State:

Postcode:

Phone 1:           Phone 2:

Email:

Postal Address (if different from above):

Suburb:

State:

Postcode:

**Legal Guardian** (if applicable) Name:

Relationship to Applicant:

Address:

Phone 1:           Phone 2:

Email:

## Demographic Information (Optional: information received will only be used for statistical purposes)

Please tick the box if you have any of the following:

Companion Card

NDIS plan

Gender:  Male  Female  Unspecified

Do you identify as an Indigenous Australian?  Yes  No

If Yes, please indicate the following:

Aboriginal  Torres Strait Islander  Aboriginal and Torres Strait Islander  Neither

Do you speak a language other than English at home?  Yes  No

If yes: Please specify language spoken: \_\_\_\_\_

Do you require an interpreter?  Yes  No

## Disability Information

Please describe all relevant disabilities and/or health conditions and how they restrict your ability to walk:

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## Reports

Please attach copies of any medical reports (e.g. x-ray, test results, General Practitioner, Specialist, Physiotherapist or Occupational Therapist reports) in support of this application. Do not include original documents as these cannot be returned to you.

**Reports and/or letters are attached to this application.**  Yes  No

## Disability Information

### 1. Mark the box that applies to your situation:

- I am unable to walk and always require the use of a wheelchair (go to Q10)
- My ability to walk is severely restricted by a permanent medical condition or disability
- My ability to walk is severely restricted by a temporary medical condition or disability

### 2. Do you use a mobility aid?

- I use a wheelchair
- I use a walking frame/wheeled walker
- I use crutches
- I use another mobility aid (please specify) \_\_\_\_\_
- I don't use a mobility aid (go to Q4)

### 3. How often do you use a mobility aid?

- Permanently
- Currently all the time but this will change
- 5 days a week
- 2-3 days a week
- Only at home
- Only when I go out

### 4. Do you use any essential health equipment?

- I use ambulatory oxygen
- I use a ventilator
- I use a CPAP machine
- I use other essential health equipment (please specify) \_\_\_\_\_
- I don't use any essential health equipment

**5. How often is your walking restricted?**

- Every day
- 5-6 days a week
- 2-4 days a week
- 1 day a week
- 2-3 days per month
- Not applicable

**6. How many metres can you walk before you stop to rest?**

*Please note examples are approximate distances only.*

- 1-10m (from your bed to another room in your home)
- 10-20m (from inside house to the driveway or front verge)
- 20-60m (basketball court length to Olympic swimming pool length)
- 60-100m (shopping centre car park into supermarket)
- 100-200m (do your grocery shopping at large supermarket)
- 200m+

**7. 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
<i>No pain</i>			<i>Medium pain</i>					<i>Extreme pain</i>		

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

**8. How do you manage your conditions?**

*(medication and dosage, past/future planned surgery, exercise, therapy, other)*

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**9. Is there any other information you would like to provide in support of your application?**

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## 10. Applicant Statement

- I agree to be contacted by the ACROD Parking Program to provide further information if required.
- 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.
- 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.
- The information in this application is correct to the best of my knowledge.

Applicant Signature

OR Legal Guardian Signature

Signature:

Signature:

Date:

Date:

## SECTION 2. Doctor/Occupational Therapist Statement

Please note a permit will not automatically be granted. All applications are subject to assessment by the ACROD Parking Program.

1. Are you the applicant's regular doctor or therapist?

Yes (go to Q3)

No

2. How long has the applicant been a patient at this practice?

First visit  
 1 month - 1 year  
 1 year plus

3. Diagnosis affecting ability to walk

Condition 1	

Functional walking issues related to this diagnosis

Objective measurements indicating the severity of the applicant's condition.  
Please attach or describe test results/specialist reports.

The condition is likely to

Deteriorate  
 Improve  
 Stay the same

If the applicant is likely to improve, when do you expect the person to be able to walk 60m without stopping to rest?

Within 6 months  
 Within 1 year  
 Within 2 years  
 2 years +



**Condition 2**

Functional walking issues related to this diagnosis

Objective measurements indicating the severity of the applicant's condition.  
Please attach or describe test results/specialist reports.

The condition is likely to

- Deteriorate
- Improve
- Stay the same

If the applicant is likely to improve, when do you expect the person to be able to walk 60m without stopping to rest?

- Within 6 months
- Within 1 year
- Within 2 years
- 2 years +

**4. If the applicant uses a mobility aid, how long will they need it?**

- 0 - 6 months
- 6 - 12 months
- 1 - 2 years
- 2 - 5 years
- Lifelong

**5. Please describe any other relevant medical information**

**6.** Is the applicant undergoing any surgery, treatment or rehabilitation that may improve their ability to walk?

Yes (please specify)


No

**7.** What is the expected duration of the treatment or rehabilitation?

Less than 6 months

6 - 12 months

1 - 2 years

Please turn over to sign 

## 8. Doctor/Occupational Therapist Details

Name:
Position:
Employer or Business Name:
Address:
Daytime Contact Number(s):
Email:
Fax:

## 9. Health Professional/Service Provider Declaration

I confirm that my signature below verifies all of the following:

- I have read and understand the ACROD Parking Program eligibility criteria;
- I have read all of the information contained in this form and verify that it is correct to the best of my knowledge;
- I am not the applicant or an immediate family member of the applicant;
- I agree to offer all reasonable information to assist the ACROD Parking Program to determine the applicant's eligibility.

Signature:

Date:

AHPRA registration number/provider  
number/professional membership  
number/stamp:



Applicant to send completed form (Section 1 & Section 2) by email, post or fax.

**Post** ACROD Parking Program, PO Box 184 Northbridge WA 6865

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

If you are deaf or hard of hearing, contact us through the National Relay Service.

**Visit** [www.relayservice.gov.au](http://www.relayservice.gov.au)



Western Australia

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