ACROD PARKING PROGRAM

National Disability Services

ACROD Parking Program
Restricted mobility certificate

This certificate must be completed and signed by a Doctor or Occupational Therapist and submitted together with the ACROD Parking Permit application form.

It is used to gather information for assessing the eligibility of a person, who has a severe walking restriction, applying for an ACROD Parking Permit.

Eligibility criteria

An applicant may be eligible for an ACROD Parking Permit if:

1. they are unable to walk and always require the use of a wheelchair, mobility or medical aid; or
2. their ability to walk is significantly restricted by a permanent disability or medical condition; or
3. their ability to walk is significantly restricted by a temporay disability or medical condition (for a minimum of six months).

Assessment of applications

The ACROD Parking Program assessment team will assess each application against the eligibility criteria. If more information is needed to determine the applicant's eligibility, the ACROD Parking Program may contact the Doctor or Occupational Therapist who has signed this form to ask for additional information.

Contact information

ACROD Parking Program email: acrod@nds.org.au

Telephone: 08 9242 5544

ACROD Parking Program website: acrod.org.au

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

Further information about the application process

The main ACROD Parking Permit application form and additional information can be found in the "How to apply" section of the ACROD website at acrod.org.au/how-to-apply-individual/

Privacy statement

NDS is committed to protecting your personal information. The Privacy Act 1988 (Commonwealth) which includes the Australian Privacy Principles, regulates the way in which your personal information is collected and used. By providing us with your personal information, you consent to the terms of the NDS Privacy Policy available from our website which sets out how we collect, use, store and disclose personal information.

Applicant details

Surname:	First name:	
Residential address:		
Suburb:	State:	Postcode:
Date of birth (dd/mm/yyyy):		

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 +

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Diagnosis affecting ability to walk (continued)

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 +

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

Please describe any other relevant medical information

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

Yes (please specify)

No

What is the expected duration of the treatment or rehabilitation?

Less than 6 months

6 - 12 months

1 - 2 years

Doctor / Occupational Therapist declaration

I confirm that the applicant whose details are provided above meets the eligibility criteria for an ACROD Parking Permit as set out on page B1;

I confirm that the information in this form 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:

Doctor / Occupational Therapist details or stamp:

Full name:

Position:

Employer / clinic:

Address:

Phone:

AHPRA number: