Application for Accessible Parking Identification Permits and Plates

SECTION 1 - Please print clearly in ink.

I, ________________________________________________________________, hereby certify that I am a MOBILITY DISABLED PERSON as defined by the Regulations respecting Permits/Number Plates for Mobility Disabled Persons.

I hereby make application for ☐ Temporary Identification Number
☐ Identification Permit (Permanent Disability)
☐ Number Plates for the Vehicle described below. – PLEASE NOTE: Applicant must be Plate Owner and Operator of Vehicle.

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Address in Full:
Postal Code:

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Client Master Number:

Date of Birth:

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SECTION 2

MEDICAL CERTIFICATION
(to be completed by a qualified Medical Practitioner)

MOBILITY DISABLED PERSON means a person whose mobility is limited as a result of permanent severe physical disability caused by paralysis, lower limb amputation, heart or lung disease or other debilitating impairment to the extent that:

☐ (i) the person is unable to propel himself without the aid of a wheelchair or walker, or a combination of two of: a crutch, cane, leg brace, or leg prosthesis, or

☐ (ii) (A) the daily use of a device to assist the person with breathing is required, or

☐ (B) the person has a significant cardio-pulmonary condition which results in severe shortness of breath with minimum physical activity, or

☐ (C) the person has a severe neuro-muscular or skeletal condition, and because of any of the conditions described in paragraph (A), (B) or (C) is limited in mobility to 50 meters or less in outdoor weather conditions, or

☐ (iii) the person is legally blind in accordance with the definition of blindness in the Blind Persons Act (Canada) as may be from time to time amended.

This is to certify that the applicant named above is a PERMANENT MOBILITY DISABLED PERSON as defined above due to:

(Medical Condition)

Date

Doctor’s Signature

Please Print Name

Physician’s Phone Number

Address

SECTION 3

This is to certify that the applicant above is a TEMPORARY MOBILITY DISABLED PERSON due to:

(Medical Condition)

ANTICIPATED LENGTH OF TIME DISABILITY IS EXPECTED TO CONTINUE: ________________________________

(Maximum six months per certification)

Date

Doctor’s Signature

Please Print Name

Physician’s Phone Number

Address

SECTION 4

Application for renewal of permanent disabled ☐ Plate ☐ Permit

This is to certify that my condition has not changed as it relates to qualifying for disabled parking privileges.

Applicant’s Signature ____________________________ Date ______________________

APP11 (Rev. 09/10)