NWT Disabilities Council
Lower Level of the Scotia Centre
Suite 116, 5102 50th Avenue
Yellowknife, NT X1A 3S8

Parking Permit Application

SECTION 1 APPLICANT INFORMATION

Check one of the following:

☐ Applying for the first time
☐ Applying for the renewal of a temporary permit
☐ Applying for the replacement of a: i) lost ☐ ii) stolen ☐ or iii) damaged permit ☐
(damaged permit must be returned before a replacement is issued)

PLEASE PRINT CLEARLY – Incomplete/illegible applications will be returned.

First Name: _____ Last Name: _____ Middle: _____

Address: _____ | _____ | _____ | _____
Street Number & Name, Box Number City/Town Postal Code

Date of Birth: _____ / _____ / _____ Phone Number: _____
Month Day Year

Email Address: _____

I, the applicant, acknowledge that:

- I am applying for a parking permit and the information provided on this application is true and correct.
- The parking permit will only be used when the applicant is present. Any misuse of a parking permit will result in the permit being cancelled and the refusal to issue a parking permit in the future.
- If applying for a replacement of a lost or stolen permit, I declare that the permit is unavailable for return.
- I am responsible for advising the NWT Disabilities Council of any information changes.

Signature of Applicant or Parent/Guardian _____ Date _____

Note:
All information must be completed for processing. When the application is completed, it must be submitted to the NWT Disabilities Council within 3 months, or a new application will be required.
If there are changes to your contact information, it is your responsibility to inform the Council of your new information.

GOVERNING RULES – For complete listing of governing rules for your parking permit, please contact our office

- The parking permit is issued to you only. Any person not involved in the direct and immediate process of physically assisting you may not use it.
- Designated parking spaces are not to be used for extended periods of time (i.e. over 2 hours).
- Designated parking spaces for persons with disabilities are not to be used for parking while you are at work.
- You are responsible for any misuse of the parking permit.

NWT DISABILITIES COUNCL OFFICE USE ONLY

Permit Number: _____ Permanent Temporary Expiry date: _____

Authorized by: _____ Date: _____

Phone: **(867) 873-8230 | *Toll Free:* 1(800) 491-8885 | *Fax:* (867) 873-4124 | *Email:* admin@nwtdc.net**

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ONLY FOR NEW OR TEMPORARY REPLACEMENT PARKING PERMITS

Completed by a Physician, Occupational Therapist, Physical Therapist, Nurse Practitioner or Chiropractor.
PLEASE PRINT CLEARLY

Medical name(s) of disabling condition(s): _____

In layman terms, please describe how this condition impairs the applicant's mobility: _____

_____

Check one of the following durations:

○ **Temporary disability** where the applicant is unable to walk unassisted for more than 50 meters (164 feet) without great difficulty or danger to their health and safety but where the nature of the condition is temporary (example: broken leg).
Specify estimated length of the condition in number of months (1-6 months maximum) _____ **Months**

○ **Permanent disability** where the applicant is unable to walk unassisted for more than 50 meters (164 feet) without great difficulty or danger to their health and safety and the disability is of a permanent nature and will not improve within the next two years. The applicant will be able to shelf-declare to renew their permit and will not require verification from a healthcare professional. To be eligible for a permanent parking permit:

☐ The applicant uses a wheelchair to travel any distance.

☐ the applicant uses a mechanical aid to travel any distance. The mechanical aid is:

☐ Scooter ☐ Crutches ☐ Walker ☐ Cane ☐ Lower Limb Prosthetic Device

Other – Specify: _____

☐ The applicant has a permanent disability which is not visible such as chronic obstructive pulmonary disease (COPD), cardiovascular disease, a neurological impairment, or other permanent condition whereby walking a distance of 50 meters (164 feet) would pose a further risk or endanger their health.

Please specify: _____

Note: As the authorizing healthcare professional, you are verifying the applicant is eligible for a parking permit. Should there be any misuse or abuse of the privileges associated with the issuance of this permit, you may be requested to verify the applicant's disability.

Healthcare Professional's Name and Address (Print or use office stamp)

Full Name:	Telephone Number:	Medical Office Stamp
Address:	Fax Number:	
City/Town:	Postal Code:	

It is my opinion that the applicant is eligible for a parking permit under the criteria described above.

Signature: _____ Date: _____