Government of Alberta

Registry Agent Office use only.
Please attach
PLACARD VALIDATION

Parking Placard Application for Persons with Disabilities

Registry Agent Office use only.

Please attach BAR CODE / NUMBER Label here.

Check **ONE** only:

- ☐ First Time
- ☐ Renewal

When the application has been approved by a certified medical professional, it must be presented to a registry agent within 6 months, or a new application will have to be completed.

Section 1 APPLICANT - Person to whom the parking placard will be issued.

NOTE: A Legal Guardian/Parent or individual with Power of Attorney must sign when the applicant is under age 18 or has a disability that prevents them from completing the application.

Name of Applicant *(Last, First, Second)*	Date of Birth *year* *month* *day*
Address *Street* *City /Town* *Province* *Postal Code*	Telephone Number *(include area code)*

Are you a licensed driver? ☐ Yes ☐ No If yes, please give your Operator's Licence Number: _____

I, the applicant, acknowledge that:

- my condition, as verified in Section 2 by my certified medical professional is true;
- any misuse of a placard issued to me may result in the placard being cancelled, and
- if a placard is issued to me the information on my application may be provided to the Driver Fitnessand Monitoring Branch to be cross-referenced against my driver's record, and my primary care physician may be contacted.
- I am responsible for any costs related to completing this application.

_____ Signature of Applicant

_____ Date

Where applicable, the above statement regarding the applicant's condition must be acknowledged below by the signature of the Legal Guardian/Parent or individual with Power of Attorney.

_____ Signature of Legal Guardian/Parent or individual with Power of Attorney

_____ Name

_____ Date

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This information is being collected to administer the Parking Placards for Persons with Disabilities policy. The information is governed by the Freedom of Information and Protection of Privacy Act. Questions about the collection of this information can be directed to the Freedom of Information and Protection of Privacy Coordinator for the Alberta Government, Box 3140, Edmonton, Alberta T5J 2G7, 780-427-7013.

Section 2 A CERTIFIED MEDICAL PROFESSIONAL (physician, occupational therapist, or physiotherapist) must complete this section.

ELIGIBILITY: **Persons unable to walk more than 50 metres (150 feet).**

"Walk" is defined as "progress by lifting and setting down each foot in turn, never having both feet off the ground at once." Source: The Concise Oxford Dictionary, 2001.

1. Check **ONE** of the following boxes:

☐ Short term disability where the applicant is unable to walk more than 50 metres (150 feet) for three to twelve months. *Expected period of disability is* _____ *months.*

☐ Long term disability where the applicant is unable to walk more than 50 metres (150 feet) but the disability may improve within the next 5 years, (e.g. no longer requires the use of a wheelchair). The applicant will be required to re-apply in 5 years to determine their eligibility for a placard.

Explanation: _____

☐ Permanent disability where the applicant is unable to walk more than 50 metres (150 feet) and their disability is of a permanent nature and will not improve within the next 5 years (e.g. requires the permanent use of a wheelchair). The applicant will be able to self-declare in 5 years to renew their placard, and will not require verification from a certified medical professional.

Explanation: _____

2. Describe the nature of the applicant's disability.

_____

_____

3. Describe any limitations to the applicant's mobility.

_____

_____

4. Describe the type of aid or assistance used by the applicant, if applicable.

☐ Wheelchair ☐ Scooter ☐ Other *(specify):* _____

5. Would you recommend a complete medical report and/or a road test to assess the applicant's ability to operate a motor vehicle?

Medical Report? ☐ Yes ☐ No Road Test? ☐ Yes ☐ No

Name of Certifying Medical Professional				Telephone Number *(include area code)*
Address *Street*	*City / Town*	*Province*	*Postal Code*	
Professional Designation: ☐ Physician ☐ Occupational Therapist ☐ Physiotherapist				Registration Number

I understand that I may be asked to verify the applicant's disability in the event of misuse or abuse of the privileges associated with the issuance of this parking placard.

_____ _____

Signature of Certifying Medical Professional Date