

LAST NAME & INIT.:

PERMIT #:

DISABILITY CODE:

EXPIRES:

PROCESSED BY:

TYPE: PERM. TEMP.

DATE:

Shaded Area Is For Office Use Only

PART D: TO BE COMPLETED BY AN AUTHORIZED MEDICAL DOCTOR (please print)

GIVE MEDICAL NAME OF MOBILITY DISABILITY

HOW DOES THIS LIMIT MOBILITY? (Check all that apply)

CANNOT WALK A DISTANCE GREATER THAN 100 METRES LEGALLY BLIND

PROGNOSIS

This patient is experiencing a mobility disability that is (CHECK ONE ONLY):

PERMANENT (Permit must be renewed every 3 years)

TEMPORARY 3 Months 6 Months 1 year

ORGANIZATION

CERTIFICATION

For the above reasons, it is my opinion that the patient has a mobility disability that poses a risk to their health by walking 100 metres. I hereby certify that to my knowledge, the above information is true and correct.

SIGNATURE OF THE MEDICAL DOCTOR

DATE

Note: Stamps or photocopies will not be accepted.

| | | | |
|---|----------|-------------|------------------|
| PHYSICIAN'S NAME (Please Print) | | MSP # | ADDRESS STAMP |
| ADDRESS (Apt. No., PO Box or RR#) (Number & Street) | | | |
| CITY | PROVINCE | POSTAL CODE | TELEPHONE NUMBER |

AMOUNT DUE:

Permanent Parking Placard Fee (\$15.00) _____

Temporary Parking Placard Fee (\$25.00) _____
(\$15.00 deposit + \$10.00 placard fee. Deposit is refunded when parking placard is returned.)

Organization Parking Placard Fee (\$25.00) _____

Bumper Sticker @ \$2.00 each: Quantity: _____
(Fundraiser for Cowichan Independent Living)

T-shirt (black with white logo @ \$15.00 each
Adult sizes: Small _____ Medium _____ Large _____ X/Large _____

Tax Deductible donation: _____

TOTAL AMOUNT ENCLOSED: _____