Application form
Parking permit for people with disabilities

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Part 1 — Applicant name (person with the disability)

Last Name

First Name

Address

Suburb

Postcode

Telephone

Home:	Work:	Mobile:

Date of Birth

Select application option (tick one)

☐ Driver / Passenger ☐ Passenger only

Driver Licence Number

State

Expiry Date

What is your disability / condition?

Do you use a mobility aid? If yes, please state type of aid

Statement of acceptance

I make this declaration in the firm belief that all information provided is, to my knowledge, true and correct and I am aware that false declarations may be punishable by law. I will fully comply with the "Conditions of use" for the permit. If my circumstances change in a way likely to affect my eligibility for the permit, I agree to notify the issuing authority within fourteen (14) days. I further agree that the permit remains the property of Frankston City Council and will be returned within seven (7) day of notification of such return being required.

Applicant/Agent Name

Date

Signature

Part 2 — to be completed by a medical practitioner/specialist/clinical psychologist

Please select type of permit your patient requires (select one only)

☐ Category 1 : Disabled parking bay
Blue Permit

☐ Category 2 : Extra time in standard parking bay only
Green Permit

☐ Temporary Condition : 6 months only
Blue or Green (please circle)

DOCTOR'S AUTHORITY STAMP HERE

Part 3 — to be completed by a medical practitioner/specialist/clinical psychologist

What is your patient's disability/acute or chronic illness?

Permanent condition? ☐ YES ☐ NO

Additional space required to access vehicle? ☐ YES ☐ NO

Does your patient use a mobility aid? ☐ YES ☐ NO

What mobility aid does your patient use?

Does your patient's condition impact their capacity to walk long distances without rest breaks? ☐ YES ☐ NO

Does your patient's condition impact their capacity to walk to the extent it may endanger their health as opposed to being merely inconvenient? ☐ YES ☐ NO

Does your patient's condition result in extreme danger to themselves or others in a public place without continuous attendance of a caregiver? ☐ YES ☐ NO

Is it your medical opinion that your patient requires a Disability Parking Permit? ☐ YES ☐ NO

Is there any additional information to support this application?

Medical Authority — must be completed by a medical practitioner/specialist/clinical psychologist

I make this declaration in the firm belief that all information provided is, to my knowledge, true and correct and I am aware that false declarations may be punishable by law.

Name	
Practice	
Address	
Date	
Signature	

DOCTOR'S AUTHORITY STAMP HERE

Please return completed for Frankston City Council, Community Safety Department
IN PERSON : Civic Centre, 30 Davey St Frankston; Seaford Service Centre; Langwarrin Service Centre
MAIL : PO BOX 490, Frankston, Vic, 3199
E-MAIL : info@frankston.vic.gov.au