

# APPLICATION FORM

Tel: (604) 718-7744  
 9:00 AM - 4:30 PM  
 CLOSED THURSDAYS  
 www.sparc.bc.ca  
 NO CASH ACCEPTED



Social Planning and Research Council of British Columbia  
**PARKING PERMIT PROGRAM FOR PEOPLE WITH DISABILITIES**  
 201 - 221 East 10th Avenue, Vancouver, BC V5T 4V3

**All applications are subject to eligibility criteria  
 PLEASE DO NOT FAX OR PHOTOCOPY FOR DISTRIBUTION**

## PART A: TO BE COMPLETED BY THE APPLICANT (please print)

Have you applied for a SPARC parking permit before?  YES  NO

APPLICANT'S FIRST NAME(S) \_\_\_\_\_ FAMILY OR LAST NAME \_\_\_\_\_

MAILING ADDRESS (Apt. No., P.O. Box or RR #) \_\_\_\_\_ (Number & Street) \_\_\_\_\_

CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_  
Area Code

DATE OF BIRTH \_\_\_\_\_ YEAR MONTH DAY  FEMALE  MALE

## PART B: CONDITIONS FOR PARKING PERMIT HOLDERS

- Only one permit per Applicant will be issued. Permits issued for Permanent Disabilities must be renewed every three years. Temporary permits will be valid for a period of time as determined by your physician (maximum one-year). **All personal information will remain strictly confidential.**
- It is the applicant's responsibility to ensure that his/her physician (only) has completed PART D (on the back of this form). The applicant is responsible for ensuring this form is completed and for any charges made for its completion.
- I agree to be responsible for the appropriate use of the permit and understand this permit is for my use only. I understand the information above and hereby authorize the release of any information requested with respect to this application.

\_\_\_\_\_  
 SIGNATURE OR MARK (X) OF APPLICANT OR POWER OF ATTORNEY OR LEGAL GUARDIAN\* DATE \_\_\_\_\_

\*Power of attorney or legal guardian to sign only if applicant cannot be responsible for a legal permit.

## TO BE COMPLETED IF SIGNED BY POWER OF ATTORNEY OR LEGAL GUARDIAN

FIRST NAME(S) \_\_\_\_\_ FAMILY OR LAST NAME \_\_\_\_\_

MAILING ADDRESS (Apt. No., P.O. Box or RR #) \_\_\_\_\_ (Number & Street) \_\_\_\_\_

CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_  
Area Code

RELATIONSHIP TO APPLICANT \_\_\_\_\_

## PART C: PAYMENT (please do not send cash in the mail)

PROCESSING FEE IS \$15.00  ENCLOSED - PAYABLE TO SPARC (Please allow 2-3 weeks for processing) - NO CASH

METHOD OF PAYMENT \_\_\_\_\_ EXPIRY DATE \_\_\_\_\_

Cheque  Money Order   
 Visa  Mastercard  CREDIT CARD NUMBER \_\_\_\_\_ Month / Year \_\_\_\_\_

MY DONATION OF \$ \_\_\_\_\_ ENCLOSED (Donors of \$10 or more will receive a year's subscription to SPARC News)  
*Financial assistance may be available with a written request.*

TOTAL AMOUNT I AUTHORIZE FOR \$ \_\_\_\_\_ SIGNATURE \_\_\_\_\_

**FOR OFFICE USE ONLY - DO NOT WRITE IN THIS SECTION**

Expiry date	Expiry date	Expiry date	Expiry date	<b>PERMANENT</b> <input type="checkbox"/>
Permit #	Permit #	Permit #	Permit #	<b>TEMPORARY</b> <input type="checkbox"/>
Expiry date	Expiry date	Expiry date	Expiry date	<b>APPROVED</b> _____
Permit #	Permit #	Permit #	Permit #	<b>P.I.D.</b> _____

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

CERTIFYING MEDICAL DOCTOR must complete this section. Please note: As the authorizing medical professional, you are verifying the applicant has a disability that will pose a risk to their health by walking 100 metres. Your authorization entitles them to special disabled parking identification. Should there be misuse or abuse of the privileges associated with the issuance of this special identification, you may be requested to verify the applicant's disability and legal access to designated disabled parking spaces. The applicant is responsible for any or all costs incurred in the completion of this application.

APPLICANT'S NAME (SHOULD BE THE SAME AS APPLICANT IN PART A - SEE REVERSE)

GIVE MEDICAL NAME OF DISABLING CONDITION(S)	<b>OFFICE USE ONLY</b> (Disability Code)
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HOW DOES THIS IMPAIR MOBILITY? (Check all that apply)

- CANNOT WALK A DISTANCE GREATER THAN 100 METRES       LEGALLY BLIND

IN YOUR WORDS, DESCRIBE HOW THE DISABLING CONDITION(S) IMPAIRS THE MOBILITY OF THIS PATIENT:

**PROGNOSIS**

This patient is experiencing a mobility impairment which is (CHECK ONE ONLY):

- PERMANENT** (Permit must be renewed every 3 years)  
 **TEMPORARY**

\*PLEASE NOTE: Should a temporary permit holder require a longer period of recovery, he/she will have to reapply for a permit after the date specified.

If temporary, please give the date by which the disability is likely to cease\*:

MONTH: \_\_\_\_\_ YEAR: 20 \_\_\_\_ . **Maximum 1 year.**

**CERTIFICATION**

For the above reasons, it is my opinion that the patient has a mobility impairment 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., P.O. Box or RR #)	(Number & Street)	

CITY	PROVINCE	POSTAL CODE	TELEPHONE NUMBER <small>(Area Code)</small>
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**PART E: STATISTICAL INFORMATION (this data will help us to improve accessibility in BC)**

PLEASE INDICATE MOBILITY DEVICE(S) USED:

- Walking Aid (cane, walker, crutches, etc)       Wheelchair: ( manual or  motorized)  
 Scooter       Not Applicable       Other: \_\_\_\_\_

YOUR PERMIT WILL BE USED IN A VEHICLE WITH A: (check all that apply)

- Side Lift       Rear Lift       Raised Roof       Car       Truck       None of these

ARE YOU THE:       Driver      OR       Passenger

I REQUIRE PARKING THAT IS :       Standard Sized       Extra Wide       Extra Long