Office Use Only

ACROD Parking Program
Temporary Permit Extension Application Form

Please read the information on the enclosed letter before completing this application.

PART A: Must be completed by the applicant
PART B: Must be completed by your Doctor or Occupational Therapist

PART A. To be completed by the applicant

1. Applicant Details:

ACROD Number		Date of Birth	
Surname			
Given Names			
Street Address			
Suburb		Post Code	
Postal Address (if different from above)			
Suburb		Post Code	
Phone			

2. Do you require the use of a mobility/medical aid such as a wheelchair, crutches, walking frame or portable oxygen?

☐ No. ☐ Yes. State type_____

3. How far can you walk before you stop and rest? _____ metres

This question must be answered. To help you measure a distance, the width of one car bay generally equals 2.5 metres.

4. Describe how your body feels when you walk (i.e what are your symptoms?).

_____

5. Describe how you walk (e.g. speed, balance or how you think you look to others when you walk).

_____

6. If there are any other comments you wish to make about your walking, please attach a separate page.

7. I confirm that my signature verifies the following:

- ✓ The information contained in this application is correct to the best of my knowledge.
- ✓ The information contained in this form has been endorsed by my Doctor / Occupational Therapist (PART B) who, in turn, may disclose information about me to assist with my application.

Signature: _____ **Date:** _____

Part B. To be completed by Doctor / Occupational Therapist

Eligibility Criteria
Criteria 1: The applicant is unable to walk and always requires the use of a wheelchair; or
Criteria 2: The applicant's ability to walk is severely restricted by a permanent medical condition or disability; or
Criteria 3: The applicant's ability to walk is severely restricted by a temporary medical condition or disability.

Further information on eligibility is available by requesting the 'Health Professionals Guide'. Request a copy via app@app.org.au or 08 9242 5544.

1. **Please specify the applicant's diagnosis that impacts on their ability to walk:**

   _____

   _____

2. **How long do you anticipate the applicant's disability or medical condition will continue to severely impact on their ability to walk?** _____ months

3. **What is the reason for the applicant's continued walking restriction?** (please tick):
   - ☐ Further treatment / rehabilitation is required
   - ☐ Recovering from surgery
   - ☐ Waiting for surgery
   - ☐ Other, specify: _____

4. **Doctor / Occupational Therapist Identification (please print or stamp these details)**

Name			
Street Address			
Suburb		Post Code	
Registration No			
Email			
Phone		Fax:	

I certify that I have seen the applicant in a professional capacity and my signature below verifies all of the following:

- ✓ The information supplied within this application form is correct to the best of my knowledge;
- ✓ I am not the applicant or an immediate family member of the applicant; and
- ✓ I agree to be contacted to verify information contained in this form.

Signature: _____ **Date:** _____

Post your completed application to:
ACROD Parking Program, PO Box 184, Northbridge WA 6865

ACROD Parking Program
T 08 9242 5544 **F** 08 9242 5044 **W** www.app.org.au

National Disability Services
WESTERN AUSTRALIA