Accessible Parking Application Form - Request for Temporary Accommodation

1. APPLICANT INFORMATION – APPLICANT TO COMPLETE:

Applicant Name: _____ _____
Last *First*

Applicant Contact Info: _____
Street Name and Number

_____ _____ _____
City *Province* *Postal Code*

_____ _____
Personal Email Address *Personal Phone Number*

_____ _____
Work Email Address *Work Phone Number*

2. PHYSICIAN ASSESSMENT - PHYSICIAN TO COMPLETE

Patient Name: _____ _____
Last *First*

Patient Eligibility (Please check one):

- ☐ Applicant has a disability that affects mobility, specifically the ability to walk
- ☐ Applicant can NOT walk 100 meters without risk to health
- ☐ Applicant requires the use of a mobility aid in order to travel any distance
- ☐ Other (please explain): _____
  _____
  _____

Patient Prognosis - This patient is experiencing temporary mobility impairment, which will apply for (*please check one*):

- ☐ _____ weeks (specify the anticipated number of weeks that the mobility impairment will impact your patient)
- ☐ Three (3) months
- ☐ Six (6) months
- ☐ Nine (9) months
- ☐ Twelve (12) months (Note: One year is the maximum allowed. For longer-term needs, apply for a parking permit through SMD.)

Physician's Certification	**Physician Address Stamp**
For the above reasons, it is my professional, medical opinion that the patient as named above has a mobility impairment that poses a risk to their health by walking greater than 100 metres. I hereby certify that, to my knowledge, the above information is true and correct.	

Physician Name *(PRINT)*: _____
Physician Signature: _____
Date: _____ **Physician Phone Number**: _____

This document is available in alternate formats upon request.