

**SECTION 1 – All APPLICANTS TO COMPLETE, AND SIGN WHERE INDICATED.**

<b>NAME:</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms _____		<b>PHONE:</b> _____		
<b>MAILING ADDRESS:</b> _____		<b>BIRTH DATE:</b> _____	_____	
		dd	mm yy	
<b>CITY / TOWN:</b> _____		<b>POSTAL CODE:</b> _____		
<b>DATE:</b> _____	<b>SIGNATURE of Applicant (required):</b> _____			
<b>Contact Person:</b> _____				
<small>(Family, friend, neighbor)</small>	NAME	RELATIONSHIP	ADDRESS	TELEPHONE

**Under *The Highway Traffic Act* and its regulation a “physically disabled person” means:**  
**A PERSON WHO IS DISABLED IN SUCH A WAY AS TO BE UNABLE TO WALK UNASSISTED FOR MORE THAN 50 METERS**  
**WITHOUT GREAT DIFFICULTY OR DANGER TO THE PERSON’S HEALTH OR SAFETY.**  
We reserve the right to require medical information at any time to verify whether the applicant meets the definition.

**Please ENCLOSE a \$15.00 non-refundable processing fee by cheque or money order, payable to the “Parking Permit Program”. Interac & Credit cards available in office.**

**Submit your application by mail to:**

**PARKING PERMIT PROGRAM**  
1857 Notre Dame Avenue  
Winnipeg, MB R3E 3E7  
Phone 204-975-3257  
Toll Free 1-844-975-3257  
Hours: 8:00am – 4:00pm Mon.-Fri.

SMD'S privacy practices reflect obligations under the Personal Information Protection and Electronic Documents Act of Canada (“PIPEDA”) and the Freedom of Information and Protection of Privacy Act of Manitoba (“FIPPA”) as well as the Personal Health Information Act of Manitoba (“PHIA”) regarding the collection, use and disclosure of personal information in all of our activities.

**Administered by the Society for Manitobans with Disabilities on behalf of the Province of Manitoba.**

**MEDICAL PROFESSIONAL TO COMPLETE REVERSE SIDE**

**SECTION 2** – Must be completed and certified only by a licensed medical Physician, Registered clinic based Nurse Practitioner, Chiropractor, Occupational Therapist or Physiotherapist.

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A PERSON WHO IS DISABLED IN SUCH A WAY AS TO BE UNABLE TO WALK UNASSISTED FOR MORE THAN 50 METERS WITHOUT GREAT DIFFICULTY OR DANGER TO THE PERSON’S HEALTH OR SAFETY.

**APPLICANT’S NAME:** \_\_\_\_\_

Medical name(s) of Applicant’s Diagnosis(s): \_\_\_\_\_

\_\_\_\_\_

The Applicant meets the definition of a “physically disabled person” as stated above.  Yes  No

Please explain clearly how the Applicant’s condition meets the definition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Select only **ONE** of the following. The applicant is a “physically disabled person” who requires a permit on a:

\_\_\_\_\_ **Temporary basis**, (3 – 36 months). Prognosis to change within 36 months.

Term required \_\_\_\_\_ months.

\_\_\_\_\_ **Permanent basis, BUT**, does not require ongoing assistance of a mobility aid. (Permit issued for 36 months.) e.g. chronic obstructive pulmonary disease, multiple sclerosis, Parkinson’s disease

\_\_\_\_\_ **Permanent basis, AND**, requires ongoing assistance of a mobility aid. (Permit issued for 36 months.) e.g. wheelchair, walker, crutches

**CERTIFICATION AUTHORITY:** To be completed by a Medical Physician, Registered clinic-based Nurse Practitioner, Chiropractor, Occupational Therapist or Physiotherapist.

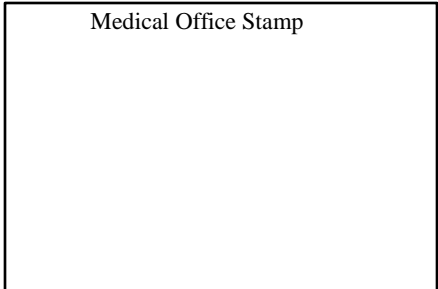
**Note:** As the authorizing medical professional, you are verifying the applicant meets the definition of “physically disabled person” defined above. The applicant is responsible for any and all costs incurred in the completion of this application.

Name: \_\_\_\_\_ Position/ Title: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_\_



**Certification:** It is my opinion that the applicant is eligible for a parking permit under the legislated criteria. I fully completed this side of the application.

\_\_\_\_\_  
Signature of Medical Professional

\_\_\_\_\_  
Registration Number

\_\_\_\_\_  
Date