

PARKING PERMIT PROGRAM
FOR PERSONS WITH PHYSICAL DISABILITIES

Administered by the Society for Manitobans with Disabilities



PARKING PERMIT PROGRAM
1111 Winnipeg Avenue
Winnipeg, MB. R3E 0S2
Phone (204) 975-3257
Toll Free 1-800-836-5551
Hours: 8:00am – 4:00pm Mon.-Fri



Submit applications by mail. **ENCLOSE a \$12.50** non-refundable processing fee by cheque or money order, **payable to the "Parking Permit Program"**. No credit cards or Interac.

Ce formulaire existe aussi en français

NEW APPLICANTS: SECTION 1 AND 2 REQUIRED.

RENEWALS: Section 2 is required if the previous medical certification does not indicate ongoing use of a mobility aid or was temporary.

SECTION 1: All disabled applicants must complete, sign where indicated and enclose \$12.50 payment. (Incomplete applications will be returned.)

SECTION 2: Completed only by a Physician, Registered Clinic-Based Nurse Practitioner, Chiropractor, Occupational Therapist or Physiotherapist.

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

NAME: Mr Mrs Ms _____ PHONE: _____
ADDRESS: _____ BIRTH DATE: M____/D____/Y_____
CITY / TOWN: _____ POSTAL CODE: _____
DATE: _____ SIGNATURE of Applicant(required): _____
Applicant or Legal Guardian or Power of Attorney – DOCUMENTATION REQUIRED
Contact Person: _____
(Family, friend, neighbor) NAME RELATIONSHIP ADDRESS TELEPHONE

The Parking Permit Program may issue a permit to a “physically disabled person” described in the definition below. We reserve the right to require medical information at any time to verify whether the applicant meets the definition.

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.

Select only ONE of the following boxes which applies to you – complete fully.

I am physically disabled person as defined above, **AND I require** the ongoing assistance of a the following mobility aid(s) for movement, which is/are: _____.
My disability is _____.
My disability is permanent.
I declare the above information is true. SIGNATURE of Applicant :

OR

I am a physically disabled person as defined above. I have a permanent disability but do not require the ongoing assistance of a mobility aid for movement. **Or**, I have a temporary disability.
My disability is _____
Section 2 must be completed unless medical certification states that an ongoing mobility aid is required for a permanent disability.

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.

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

Under *The Highway Traffic Act* and its regulations 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.

APPLICANT’S NAME: _____

Medical name(s) of Applicant’s condition(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: _____

Medical Office Stamp

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