smd SERVICES

PARKING PERMIT PROGRAM
FOR PERSONS WITH PHYSICAL DISABILITIES
Administered by the Society for Manitobans with Disabilities

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

NAME: ☐Mr ☐Mrs ☐Ms _____ **PHONE:** _____

MAILING ADDRESS: _____ **BIRTH DATE:** ____ ____ ____
dd mm yy

CITY / TOWN: _____ **POSTAL CODE:** _____

DATE: _____ **SIGNATURE of Applicant (required):** _____

Contact Person: _____
(Family, friend, neighbor) **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
Our office hours are 8:00 to 4:00; processing of PPP applications ends at 3:30 pm.

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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APPLICANT'S NAME: _____

Applicant's Diagnosis(s): _____

_____

_____

_____

_____

_____

_____

_____

_____

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,** (Renewable every 3 years)

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 Address 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