

McMaster University Accommodation Parking Permit Application Form

Section 1 – Completed by Applicant

Freedom of Information and Consent to Release Information

In accordance with the provisions of the Freedom of Information and Protection of Privacy Act, I authorize the release of medical information for the completion of this form to McMaster University Security & Parking Services.

Signature of Applicant: _____

Date: _____

**Section 2 – to be completed by a Canadian Regulated Health Practitioner
Regulated Health Practitioner Information**

I am registered with:

- College of Physicians & Surgeons of Ontario (CPSO)
- College of Occupational Therapists of Ontario(COTO)
- College of Physiotherapists of Ontario (CPO)
- College of Chiropractors of Ontario (CCO)
- College of Nurses of Ontario (CNO)

Please Print or Stamp Name & Address of Regulated Health Practitioner
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**Section 3 – to be completed by a Canadian Regulated Health Practitioner
Medical Information**

Estimated Length of Temporary Disabling Condition: _____

Specify estimated length of the condition in number of months (*up to 8 months*). (*For conditions lasting longer than 8 months, a Ministry of Transportation Accessible Parking Permit Application Form may have to be completed instead.*)

Eligible Conditions (Circle one or more):

- A. Cannot walk without assistance of another person or a brace, cane, crutch, a lower limb prosthetic device or similar assistive device or who requires the assistance of a wheelchair.
- B. Who suffers from lung disease to such an extent that forced expiratory volume in one second is less than 1 litre.
- C. For whom portable oxygen is a medical necessity
- D. Cardiovascular disease impairment classified as Class III or Class IV to standards accepted by the American Heart Association or Class III or IV according to the Canadian Cardiovascular Standard.
- E. Who is severely limited in the ability to walk due to an arthritic, neurological, musculoskeletal or orthopedic condition.
- F. Whose visual acuity is 20/200 or poorer in the better eye with or without corrective lenses or whose greatest diameter of the field of vision in both eyes is 20 degrees or less.
- G. Who has a condition or conditions or functional impairment that severely limits his or her mobility.

Certification:

I certify that the applicant meets the necessary eligibility requirements as listed above.

Registered Health Practitioners Reg./Lic. No.: _____

Telephone Number: (____) _____ - _____

Fax Number: (____) _____ - _____

Signature of Regulated Health Professional

Office Use Only		
Account #:	Permit #:	Permit Expiry Date: