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

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 2 months). (For conditions lasting longer than 2 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

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