McMaster University Accommodation Parking Permit Application Form

Section I — Completed by Applicant

Freedom of Information and Consent to Release Information

In accordance with the provisions of the Freedom of Information and Privacy Protection 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)

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 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

Office Use Only

Please Print or Stamp Name & Address of Regulated Health Practitioner

Account #: Permit: Permit Expiry Date: