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PART 1: MEDICAL CERTIFICATION

Disability defined for parking permit purposes:

“Anyone with a marked impairment of mobility who is unable to walk more than 75 meters without serious difficulty or danger to safety or health”

Full Name of Applicant: _____ Date: _____

Please indicate nature of mobility impairment:

_____ Quadriplegia _____ Paraplegia _____ Arthritis _____ Amputation
 _____ Emphysema _____ Heart _____ Back/Hip _____ MS/MD
 _____ Cerebral Palsy _____ Age Related _____ Other _____

Is the mobility impairment permanent? _____ or temporary (three months or less)? _____

Physician’s name: (please print): _____ Physician’s signature: _____

PART 2: PARKING PERMIT APPLICATION

Name: _____ Birthday: _____
 Mailing Address: _____ Disability: _____
 _____ Telephone: _____
 _____ E-mail: _____
 Postal Code: _____ County: _____

“I have read the regulations governing parking permits and agree to abide by them. I understand that abuse or misuse of my permit will result in the permit being cancelled.”

Signature of Applicant: _____ Date: _____

Applications cannot be approve until Part 1 and Part 2 are completed.

PART 3: FOR OFFICE USE

_____ **PERMIT #** _____
 _____ **Temporary Permit Expires** _____
 _____ **Donation Receipt #** _____
 _____ \$21.00 Permit Fee including Membership
 _____ \$30.00 For Temporary Permit (3 Months or less) \$20.00 refundable
 _____ Donation to support ResourceAbilities
 _____ **Total - Please make cheques payable to “ResourceAbilities”**

Cash/Debit _____ Cheque ___ # _____ Staff initials: _____ Date _____

Debit available only at Charlottetown office