

Application for a NEW Permanent Australian Disability Parking Permit - Individual



Please allow 14 working days for processing. Incomplete applications will not be processed.

Only one permit per applicant which *must be renewed every 3 years*.

- **Applicant** to complete Section 1 and Section 2 in Full.
- **Medical Practitioner** to complete Section 3 in Full.
- **See Conditions of Use** on the Alice Springs Town Council website.

Fees can be found at
alicesprings.nt.gov.au

Section 1

Applicant Details

Surname:		Given Name/s:	
Date of Birth:			
Residential Address:			
Postal Address:			
Email:		Mobile:	
Other Phone:			

IF APPLICABLE – Details of:

Parent

Guardian

Power of Attorney

Surname:		Given Name/s:	
Email:		Mobile:	

DECLARATION: I, the undersigned understand the permit is for the **APPLICANTS USE ONLY**. The applicant must be in or using the vehicle which has the permit displayed. Any abuse or misuse of the permit may result in the permit being revoked by the Alice Springs Town Council. I have read, I have understood, and I am bound by the conditions of use and applicable Territory and Federal legislation.

Signature: _____

Date: _____

(Signature of Applicant/Parent/Guardian/Power of Attorney)

Section 2

Instructions on getting the permit to you

Call me to collect

Email me to collect

Post my permit

If you do not collect your permit within 2 weeks of being called or emailed it will be posted.

Please submit your completed form:

- In person to – Civic Centre Reception, 93 Todd Street, Alice Springs, NT 0870
- By email to – astc@astc.nt.gov.au By fax to – (08) 8953 0588
- By post to – Alice Springs Town Council, PO Box 1071, Alice Springs, NT 0871
- Please call the Council on (08) 8950 0500, if you require further assistance.

Section 3**Medical Practitioner**

This section must be completed in full by a Medical Practitioner.

Name of Medical Practitioner:

Provider Number:

Practice Name:

Practice Address:

Contact Phone Number:

Email:

I have seen and assessed the below applicant in a professional capacity. I certify the applicant meets the eligibility criteria for a disability parking permit.

Applicants Surname:

Applicants Given Name/s:

Physical Impairment/Condition of the Applicant:

Requires use of a Wheelchair:

Requires use of a walking aid:

Is permanently blind:

Other: (Please provide further details below)

Detailed description of impairment/condition and how it affects the applicant's mobility (to be completed):

Signature: _____

(Signature of Medical Practitioner)

Date: _____

Receipt No.: _____