Ontario

Application for an Accessible Parking Permit (APP)

- Submit your completed application: online at Ontario.ca /get-an-accessible parking permit, take to a ServiceOntario centre or mail to: ServiceOntario, PO Box 9800, Kingston ON K7L 5N8.
- To apply for, renew or replace an APP, you may be required to provide proof of full name, date of birth and signature.
- Permanent Renewals expired more than 1 year require new Regulated Healthcare Practitioner certification.
- Applications are valid up to 6 months from the Regulated Healthcare Practitioner signature date.

Part A – To be completed by Applicant (or authorized third party representative)

Section 1: APP Information

Enter current or previous APP Permit Number (if applicable) _____

Type of Application

☐ New permit ☐ Renewal permit

☐ Change of Information ► ☐ Address Change ☐ Name Change ☐ Other

☐ Replacement ► ☐ Lost/Missing

☐ Stolen ► Name of Police Services _____

Police Occurrence Number _____

☐ Damaged ► (Attach damaged permit to this application)

☐ Returning Permit (attach permit) ► ☐ On behalf of deceased ☐ No longer required ☐ Found ☐ Other

Section 2: Applicant Information (Note: Third party representatives must provide ID and documentation confirming authorization)

Last name of applicant	First name of applicant	Middle name of applicant

Date of Birth (yyyy/mm/dd)	Gender	Telephone Number	Email Address

Residential Address

Street Number	Street Name or Lot, Concession, Township	Apartment / Unit Number

City, Town or Village	Province	Postal Code

Mailing Address (only complete if different from residential address above)

Street Number	Street Name or Lot, Concession, Township	Apartment / Unit Number

City, Town or Village	Province	Postal Code

Will you be a passenger or a passenger/driver in the vehicle the APP will be displayed in?

☐ Passenger/Driver (P/D) ☐ Passenger (P) Ontario driver's licence number _____

Declaration (Permits are assigned to an individual, not a vehicle)

- I solemnly declare that the information made above is true and understand that any false statements will be forwarded to the relevant law enforcement authority for investigation of an offence under the *Criminal Code* and the *Highway Traffic Act*, and could result in the cancellation of my permit, a fine and/or imprisonment. Under the *Highway Traffic Act*, it is an offence to fraudulently obtain an Accessible Parking Permit and any person who contravenes the Act may be liable for a fine of up to $5,000.
- I authorize the release of health information for the completion of this form to ServiceOntario.

Signature of ► ☐ Applicant ☐ Parent/Legal Guardian (for children under 18 years of age) ☐ Authorized Representative (for adults over 18 years of age, evidence required)

Signature	Date (yyyy/mm/dd)
X	X

By signing above, I understand and consent to the collection, use and disclosure of personal information in this application by ServiceOntario for the proper issuance, renewal, or replacement of accessible parking permits and to administer the Accessible Parking Permit Program under the authority of section 2(1) of O. Reg 581 under *Highway Traffic Act*, R.S.O. 1990, c H.8, ServiceOntario may verify the information provided in accordance with this application with health practitioners, jurisdictions, or other ministries to determine whether to issue, renew or replace the accessible parking permit. In addition, I authorize the Ministry of Health (MOH) to disclose information about me from MOH's database consisting of full name, residential address, date of birth, sex and death status in order to verify the information provided in accordance with this form and that, for the purpose, Service Ontario is obtaining my consent on behalf of the MOH. If you have questions about the collection, use and disclosure by ServiceOntario of the personal information provided in accordance with this application, please contact: Team Manager, ServiceOntario Contact Centre, PO Box 105, 777 Bay Street, Toronto ON M5G 2C8. Telephone:416-235-2999. Toll free: 1-800-387-3445. TTY Toll free: 1-800-268-7095.

Please ensure you keep a copy for your records

  Disponible en français Print Form Clear Form

Part B – To be completed by a Regulated Healthcare Practitioner

A regulated healthcare practitioner must complete the first and last name of the applicant and Sections 1, 2 and 3 below. Health documents filed in support of this application are privileged – subject to the confidentiality provisions of the *Freedom of Information and Protection of Privacy Act*. **Not required for permanent renewals, change of information or replacement**.

Last name of applicant	First name of applicant

Section 1: Assessment of Health Conditions

To be eligible for an APP, a regulated healthcare practitioner must certify that the applicant has one (1) or more of the following health conditions:

- ☐ **A** Cannot walk without the assistance of another individual or of a brace, cane, crutch, lower limb prosthetic device or similar assistive device or who requires the assistance of a wheelchair
- ☐ **B** Suffers from lung disease to such an extent that his or her forced expiratory volume in one second is less than 1 litre
- ☐ **C** Portable oxygen is a medical necessity
- ☐ **D** Suffers from cardiovascular disease to such an extent that the individual's functional capacity is classified as Class III or Class IV according to "Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels"
- ☐ **E** Ability to walk is severely limited due to an arthritic, neurological, musculoskeletal or orthopedic condition
- ☐ **F** Visual acuity is 20/200 or poorer in the better eye, with corrective lenses if required or whose maximum field of vision using both eyes has a diameter of 20 degrees or less
- ☐ **G** Mobility is severely limited by one or more conditions or functional impairments ("persons with a disability")

Section 2: Status of Condition - Select 1 Only

- ☐ Permanent (condition is not expected to improve with time)
- ☐ Subject-to-change (requires a health assessment every five (5) years)
- ☐ Temporary ► Months ____ Enter estimated length of the condition in months (**maximum 12 months**)

Section 3: Regulated Healthcare Practitioner Information

Full name of regulated healthcare practitioner	College number

Telephone Number ext.	Fax Number

I am registered with:

- ☐ College of Physicians & Surgeons of Ontario
- ☐ College of Occupational Therapists of Ontario
- ☐ College of Physiotherapists of Ontario
- ☐ College of Chiropractors of Ontario
- ☐ College of Nurses of Ontario (Nurse Practitioner-E/C)
- ☐ College of Chiropodists of Ontario

Please print or stamp **Name & Address** of Regulated Healthcare Practitioner

Declaration

- I certify that the applicant meets the necessary eligibility requirements as listed above and confirm that I am not treating myself or family members I, the undersigned, declare that the information I have provided above to be true and complete, and understand that any false statements will be forwarded to the relevant law enforcement authority for investigation of an offence under the *Criminal Code* and *Highway Traffic Act*, and could result in fine and/or imprisonment. I understand that any false statements will also be forwarded to the applicable College of a health profession in Ontario for investigation of professional misconduct under the *Health Professions Procedural Code*.
- I, the undersigned, declare that the information I have provided above to be true and complete

Signature of Regulated Healthcare Practitioner	**Date (yyyy/mm/dd)**
X	**X**

Office Use Only

Office Number	Operator Number	Business Date (yyyy/mm/dd)	Interim Permit Number

Applicant ID(s) presented	ID Document Number	Name on ID Document
Third Party ID(s) presented	ID Document Number	Name on ID Document

Third-party authorization attached? ☐ Yes ☐ No	Ontario Health Card viewed? ☐ Yes ☐ No (Important! Do not record health card numbers)