

SECTION 1 – Applicant or power of attorney or legal guardian must sign or application will be returned. If you are the power of attorney for the applicant, **a copy of your POA** must be attached. **PLEASE PRINT CLEARLY.**

NAME: <input type="checkbox"/> A AFS Mr <input type="checkbox"/> A AFS Mrs <input type="checkbox"/> A AFS Ms _____	PHONE: _____
MAILING ADDRESS: _____	BIRTH DATE: _____ mm dd yy
CITY / TOWN: _____	POSTAL CODE: _____
DATE: _____	SIGNATURE of Applicant (required): _____
Contact Person: _____ (Family, friend, neighbor)	NAME RELATIONSHIP ADDRESS TELEPHONE

Under The Highway Traffic Act and its regulation a “physically disabled person” means: **a person who is disabled in such a way as to be unable to walk unassisted for more than 50 meters without great difficulty or danger to the person’s health or safety.**

We reserve the right to require medical information at any time to verify whether the applicant meets the definition.

METHOD OF PAYMENT – Application processing fee \$15.00. Processing fee is non-refundable.

Cheque or Money order payable to the Parking Permit Program. **(NO CASH ACCEPTED)**

Interac machine available in office.

Submit your application by mail or in person to:

PARKING PERMIT PROGRAM
1857 Notre Dame Avenue Winnipeg, MB R3E 3E7
Phone 204-975-3257
Toll Free 1-844-975-3257

Our office hours are 8:00 to 4:00 Monday – Friday. Processing of PPP applications ends at 3:30 pm.

Manitoba Possible’s privacy practices reflect obligations under the Personal Information Protection and Electronic Documents Act of Canada (“PIPEDA”) and the Freedom of Information and Protection of Privacy Act of Manitoba (“FIPPA”) as well as the Personal Health Information Act of Manitoba (“PHIA”) regarding the collection, use and disclosure of personal information in all of our activities.

Administered by Manitoba Possible on behalf of the Province of Manitoba.

MEDICAL PROFESSIONAL TO COMPLETE REVERSE SIDE

SECTION 2 – Must be completed and certified only by a licensed medical Physician, Registered clinic-based Nurse Practitioner, Chiropractor, Occupational Therapist or Physiotherapist.

Under The Highway Traffic Act and its regulations a “physically disabled person” means: **A person who is disabled in such a way as to be unable to walk unassisted for more than 50 meters without great difficulty or danger to the person’s health or safety.**

APPLICANT’S NAME: _____

Applicant’s Diagnosis(s): _____

Select only **ONE** of the following. The applicant is a “physically disabled person” who requires a permit on a:

_____ **Temporary basis**, (3 - 36 months). Prognosis to change within 36 months.
Term required _____ months.

_____ **Permanent basis**, (Renewable every 3 years)

CERTIFICATION AUTHORITY: To be completed by a Medical Physician, Registered clinic-based Nurse Practitioner, Chiropractor, Occupational Therapist or Physiotherapist. **Note: As the authorizing medical professional, you are verifying the applicant meets the definition of “physically disabled person” defined above. The applicant is responsible for any and all costs incurred in the completion of this application.**

Name: _____ Position/ Title: _____
Address: _____ City/Town: _____
Postal Code: _____ Phone Number: _____



Certification: It is my opinion that the applicant is eligible for a parking permit under the legislated criteria. I fully completed this side of the application.

Signature of Medical _____ Registration _____ Date _____