

Parking Design Team, Building 4, North London Business Park,
Oakleigh Road South, London N11 1NP

Application Form For A Disabled Persons' Parking Place

Please complete the application below using BLOCK CAPITALS and return it to the above address.

A Resident's Details

Title (Mr/Mrs/Miss/Ms/Other) Full Name

Address

..... Post Code

Telephone No

Please complete and tick the relevant boxes where appropriate

1	(a) I am the disabled driver of the vehicle for which the parking place has been requested. OR (b) I confirm thatwho resides at my address is my nominated driver of the vehicle for which the parking bay has been requested.	<input type="checkbox"/> <input type="checkbox"/>
2	(a) I have no off-street parking facility such as a garage, driveway or hard standing in my garden where I can park. OR (b) I have an off-street parking facility such as a garage, driveway or hard standing in my garden but I cannot use it to park on because:	<input type="checkbox"/> <input type="checkbox"/>
3	Council Officers will visit your road to assess the parking situation. The next section will help us to make the assessment at the most suitable time(s). Parking in my street is most difficult during: (a) Weekdays – morning (b) Weekdays – afternoon (c) Weekdays – evening (d) Weekends – morning (e) Weekends – afternoon (f) Weekends – evening	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4	I enclose copies of supporting documents (a) Copy of (both sides) of my current disabled badge (b) Copy of my / my nominated driver's driving licence (delete as appropriate) (c) A form completed by my G.P. (or other authorised medical source) supporting my application and stating the extent to which my ability to walk is impaired (d) Copy of my vehicle registration document	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

I declare that all the information I have given is correct

Signed Date

Guidance And Criteria For The Provision Of A
Disabled Persons' Parking Place

1. The applicant **must** be the holder of a current Blue Badge, issued under the Disabled Persons (Badges for Motor Vehicles) Regulations.
2. The applicant should be the driver of the vehicle for which the parking space is to be provided; **or**
3. The applicant should be the passenger of the vehicle for which the parking space is to be provided where:
 - a. The applicant requires physical assistance from the driver of the vehicle when entering or leaving the vehicle and the driver is generally the only person available to assist the applicant. The driver should also live at the same address as the applicant.
 - b. The applicant is sufficiently mentally or physically incapacitated to necessitate constant supervision by the driver of the vehicle. The driver of the vehicle should be the only person available to effect this supervision and should also live at the same address as the applicant.
 - c. The applicant is between the ages of 2 and 17 years and meets either or both of the criteria stated in sections a and b above.

In addition:

4. The applicant must provide written medical evidence that they or the person for whom the application is being made has considerable difficulty in walking.
5. Disabled person's parking places will only be provided where in the opinion of the Council there is proven difficulty in parking in the vicinity of the applicant's property and no suitable alternative off-street parking is available.
6. Where off-street parking facilities are available, a parking place may be provided if the applicant can demonstrate that the facilities are unsuitable for the use of a disabled person due to the nature of their disability.

If you have any queries, please contact the Parking Design Team on 020 8359 7541 or email: parking.permit-team@barnet.gov.uk

B Patient's Details

Section B is to be completed by the applicant's GP or Doctor

Practice Name:	Practice Address:	Practice Stamp
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Confidential

Patient's Name:
Patient's Address:

This is to confirm that the above named person is at my practice and suffers from a disability affects their ability to walk to such an extent that they are in need of a disabled person's parking place.

The distance that he / she is able to walk without stopping, experiencing severe discomfort or without help from another person is (approximately);

Distance in metres	0	0-10	10-20	20-50	50-100	Over 100
Please tick in the appropriate column						

Does the applicant require the use of crutches: Yes/No
 Does the applicant require the use of a wheelchair: Yes/No

Please give a brief description of the applicant's disability:

.....

The patient's condition is temporary / permanent / degenerative. (Please delete as appropriate)
 If condition is temporary, please state the approximate length of time that the patient is likely to be affected.

I support this patient's application for a disabled persons parking bay.

Doctor's Name.....

Signed Date

If you feel there is any other relevant information you can give to support this application, please write on the back of this page or on a separate sheet.