Application for a **Temporary**
Australian Disability Parking Permit -Private Individual

Please allow 14 working days for processing. Incomplete applications will not be processed.
A Temporary Permit *cannot exceed 12 months at a time.* These permits are not renewed.

If on expiry another permit is required this application form must be completed again in full.

- **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.

Section 1 Applicant Details

Surname: _____ Given Name/s: _____

Date of Birth: Day/Month/Year

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 temporary disability parking permit.

Applicants Surname:

Applicants Given Name/s:

How many months: Cannot exceed 12 months.

Temporary Impairment/Condition of the Applicant:

Requires use of a Wheelchair: ☐ Requires use of a walking aid: ☐

Their mobility is affected by a temporary debilitating condition: ☐

Detailed description of impairment/condition (to be completed):

Signature: _____ Date: _____

(Signature of Medical Practitioner)