

# Medical Recommendation Template for Disabled Persons Parking Bay

This template is intended to assist medical professionals in providing necessary documentation for individuals applying for a disabled persons parking bay. Please complete all sections accurately to ensure proper consideration of the application.

Medical Recommendations are only accepted from:

Consultant

Specialist Nurse

Physiotherapist

## Medical Professional's Recommendation

Applicant's Name: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

Medical Professional's Name: \_\_\_\_\_

Medical Professional's Designation: \_\_\_\_\_

Medical Practice Address: \_\_\_\_\_

Date of Recommendation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Medical Condition

Diagnosis/Medical Condition: \_\_\_\_\_

## Impact on Mobility and/or safety on or around public highways

Please describe how the applicant's medical condition/disability affects their mobility or ability to safely negotiate the public highway to access their vehicle:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Benefits of a Disabled Persons Parking Bay

Please explain how the provision of a disabled persons parking bay would improve the applicant's quality of life and ability to access the community:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Declaration

I, the undersigned, confirm that the information provided above is accurate to the best of my knowledge and belief.

Signature of Medical Professional: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Contact Number: \_\_\_\_\_

Please attach any relevant supporting medical documentation, if available.