Mobility Impairment Form

FORM PS-P-01

Parking at QUT is extremely limited and is allocated on a needs basis. This form has been designed to obtain information regarding the applicant's medical condition, either physical or psychological, which impacts their ability to access the campus. This form must be completed by an accredited medical professional. All information captured on this form will be treated with confidence in accordance with the QUT Privacy Policy, MOPP F/6.2 Information Privacy.

Application Number		**Parking Period**	

Details of Medical Condition

I have examined _____ and certify that he/she
Applicant's Full Name

is suffering from a medical condition which impacts his/her ability to access the University. This condition is:

_____
Description of Medical Condition

_____

In my professional opinion, the condition noted above will impact the applicant's mobility as:

☐ It is significantly difficult for the applicant to use public transport.

☐ The applicant is unable to walk more than _____ metres without undue pain or further aggravating their medical condition.

☐ The applicant is unable to navigate steep hills or slopes of more than _____ metres length without undue pain or further aggravating their medical condition.

This form is valid for a SINGLE PARKING PERIOD only and must be signed no earlier than 30 days prior to the commencement of that parking period.

Please refer to qut.edu.au/parking for Parking Periods and dates.

Applicants with a permanent medical condition which impacts their mobility should consider applying for a government issued Disability Parking Permit. Visit https://www.qld.gov.au/disability/out-and-about/parking-permits/ for more information.

I understand that a Parking Services officer from the University may contact me to seek further information about the information supplied in this form.

☐ I have discussed this with my patient and received authority to disclose relevant information.

I declare the above information is true and correct as at _____
Date

_____
Name of Medical Practitioner

_____
Signature

Name and Address of Medical Practice (or Stamp)