

**HEALTH PERMIT APPLICATION**

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| **SECTION 1 APPLICANTS DETAILS** |

**Surname**  **Initials Title**

**Job Title Department**

**Date Base**

**of birth**

**Telephone** **Work Telephone**

**Number Number**

**Home Work email**

**Address Address**

**Banding**

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| **SECTION 2 HEALTH PERMIT APPLICATION FORM** |

**For space allocation purposes, please provide the following employment information:**

**Full Time (above 20 Hours) Part Time (20 Hours or below)**

**If you work part-time, please state the days and hours that you typically work in the box below**

**I agree:**

* **To comply with the Terms and Conditions governing the use of the Trust Car Parks and to update the Car Parking Office immediately of any change in circumstance that may affect my eligibility to this parking permit**

**Signature Date**

 ***If this document has been electronically completed please tick to confirm that the type written signature above is a legal representation of your signature***

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| **SECTION 3 YOUR CIRCUMSTANCES** |

 **Criteria Detail Tick as**

  **Appropriate**

**Permanent application:**

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| * **You have a long term medical condition which results in fatigue i.e. chronic fatigue syndrome, multiple sclerosis or you are undergoing treatment/therapy for a debilitating disease**
* **You have a long-term medical condition which makes it impossible for you to travel to work by any means other than a car and which means you need to park within the hospital grounds.**
* **You have a permanent and substantial disability which means you are unable to walk or have very considerable difficulty in walking.**
* **You are only able to walk very short distances without needing to rest or without requiring the assistance of another person.**
* **You regularly require the use of a walking aid – such as a wheelchair, walking frame, a stick or a leg brace.**
* **You are registered as blind or partially sighted with your local authority.**

**Temporary application:*** **You have undergone surgery, are undergoing treatment or have had an accident which has left you with a temporary mobility impairment.**
* **You are experiencing a difficult pregnancy that makes it impossible for you to travel to work by any means other than a car and which means you need to park within the hospital grounds.**
* **You are in the latter stages of your pregnancy (i.e. no more than 4 weeks before you are due to commence your maternity leave).**
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**Please provide the start date of your maternity leave**

**Please give details of the nature of your medical condition and the impact that it has on your ability to reach your place of work, focusing on any restrictions in terms of access to alternative means of travel. Ensure that you provide as much detail as possible to demonstrate why a car parking space would be of benefit to you in your particular circumstances. (Please continue on a separate sheet if necessary)**

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| **SECTION 4 EVIDENCE** |

**Please provide one of the following forms of evidence:**

**Medical Pro-Forma**

* **Please note that your application MUST be supported with evidence from your GP/Consultant or Occupational Health confirming any diagnosis and providing details of the impact the condition has on your mobility.**
* **If your application is pregnancy related, your application MUST be supported by your Midwife/Consultant/GP.**

**OR**

**Blue Badge**

* **Please note that your application MUST be supported with your blue badge evidence**
* **Please submit a copy of your Blue Badge (front and back) along with the application form**

**OR**

**Disability Living Allowance (or Personal Independence Payment)**

* **Please note that your application MUST be supported with your DLA-PIP evidence**
* **Please submit a copy of your DLA-PIP along with the application form**

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| **SECTION 5 DECLARATION** |

**I agree:**

* **That the details provided in this application form are accurate and complete**
* **I agree that the Trust can contact me, my GP or treating specialist or ask me to see Occupational Health if further information is required to support my application**

**Signature Date**

**If this document has been electronically completed please tick to confirm that the type written signature above is a legal representation of your signature**

**Please tick to confirm that you have attached the relevant supporting medical evidence**

**Blue Badge OR DLA(PIP) evidence OR Medical evidence**

***PLEASE NOTE A CAR PARKING PERMIT APPLICATION FORM MUST ACCOMPANY THIS FORM IF YOU HAVE NOT ALREADY APPLIED OR HAVE BEEN ISSUED WITH A PERMIT (this form can be obtained from the travel section on the Trust intranet or from the Car Parking Office).***

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| **FOR OFFICE USE ONLY** |

**Application received by Manager**

**Date**

**Evidence received and car parking permit application form if applicable**

**Recommendation of Manager (band 7 or above) and Workforce Business Partner**

**Approved Declined Pending**

**If declined, please detail the rationale below**

**Temporary permit Permanent permit**

**Please confirm if the application is for a temporary or permanent health permit?**

**Permanent Temporary**

**If for a temporary permit, please confirm the anticipated expiry date**

**MANAGER AUTHORISATION**

Name: Signature: Date:

**WORKFORCE BUSINESS PARTNER AUTHORISATION**

Name: Signature: Date:

**Facilities Manager**

**If approved, parking space to be allocated**

**Accessible Standard**

**Car Park allocated**

**SIGNED (FACILITIES MANAGER) DATE**

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| **CAR PARKING ADMIN** |

Date of permit issued:

Review date if applicable:

Payroll notified: