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The Blue European Parking Badge Application Form

Part A: Personal details

Full Name:

(Mr/Mrs/Ms/Miss)

Address:

 Postcode:

Telephone Number: Email Address:

Date of Birth: Surname at Birth:

National Insurance Number:

Please tick as appropriate:

Are you a Driver? Yes: No:

Are You a Passenger Yes: No:

Is this a First Time Application OR a Renewal:

If a renewal, what is the Badge Number:

Confirmation of address- Please provide a copy of one of the following to confirm your address, this must be dated within the last 3 months:

A Utility Bill DWP/ Benefits Letter consent to check Council Tax records

Confirmation of identity- Please provide a copy of one of the following as proof of your identity.

Driver's Licence Passport Birth Certificate

Part B: Automatic Eligibility Criteria

If you tick YES to any part of this section, you may automatically qualify for a Blue Badge. You will need to provide us with proof, as stated in each section.

1. Do you receive the higher rate mobility component of Disability Living Allowance (DLA) or the enhanced rate mobility component of the Personal Independence Payment (PIP)?

Yes No

2. Are you registered as Severely Sight Impaired/Blind?

Yes No

3. Do you receive War Pensioners' Mobility Supplement?

Yes No

If you have answered Yes to any of the questions in part B, please go to Part E.

Part C: Severe disability in both arms

Complete Part C only if you hold a valid driving licence and have a severe disability in both upper limbs and are unable to turn, by hand, the steering wheel of a vehicle, even if that wheel is fitted with a turning knob.

1. What is the nature of your disability?

2. Do you drive a specifically adapted car? Yes No

If yes, please state how the car has been adapted and produce evidence

Part D: Other Eligibility Criteria

Complete this part **ONLY** if you consider that you have a permanent and substantial disability which causes inability to walk or very considerable difficulty in walking.

Please note that all applicants who complete Part D will be required to attend a mobility assessment with the Integrated Community Therapy team at Haringey Teaching Primary Care Trust (PCT). You will be contacted directly by the PCT if you require an assessment.

1. Please describe the nature of your disability and diagnosis.

2. What medications, if any, are you prescribed?

3. Do you require a walking aid? Yes No Sometimes

If yes, please indicate which type: Wheelchair Walking stick Walking frame

Other (Please state)

4. How far can you walk without stopping, experiencing severe discomfort or requiring help from another person?

Metre(s)

5. Please describe in full, how your condition/disability affects your ability to walk.

Please print the name, address and telephone number of your family doctor. We will only contact your doctor if additional information is required to support your application.

Name	
Address	
	Postcode:
Telephone	

Part E: Declaration

Checklist

- I have enclosed confirmation of my permanent address
- I have enclosed proof of identity
- I have enclosed proof of automatically qualification as requested in Section B (Where applicable)

I declare that to the best of my belief all the statements I have made on this form are true and I agree to the local authority contacting my family doctor or internal departments within the council if necessary for the purpose of obtaining information to support my application.

Signed:

<i>Signature</i>

Print Name:

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Date:

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Please return your completed application form to :- Haringey Council, Concessionary Travel, P O Box 55290, London N22 9GA

Data Security Statement:

Haringey Council is under a duty to protect the public funds it administers, and to this end may use the information you have provided on this form for the prevention and detection of fraud. It may also share this information with other bodies responsible for auditing or administering public funds for these purposes.