Community Access Program – Medical Confirmation Form

Applicant Information:

- Full Name: _____
- Date of Birth (DD/MM/YYYY): _____
- Address: _____
- Phone Number: _____

Medical Professional Information:

- Name: _____
- Profession: _____
- Clinic/Hospital Name: _____
- Address: _____
- Phone Number: _____
- Email: _____

Medical Confirmation:

I, _____ (Medical Professional's Name), confirm that the above-named individual has a **permanent** / **short-term** (circle one) disability that prevents them from driving.

For **short-term disabilities**, the estimated timeframe for when the individual may be able to drive again is: _____.

Declaration and Signature: I certify that the information provided is accurate and based on my professional assessment.

Signature: _____

Date (DD/MM/YYYY): _____

Applicant Authorization: I, _____ (Applicant's Name), authorize the release of this medical information to the Community Access Program for the purpose of eligibility determination.

Applicant's Signature: _____

Date (DD/MM/YYYY): _____