



## 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): \_\_\_\_\_

*The personal information on this form is collected under the authority of section 4(c) of the Protection of Privacy Act to be used for the administration of the Community Access Program. If you have questions regarding the collection or use of this information, please contact the Town's Access and Privacy Officer at [accessandprivacy@okotoks.ca](mailto:accessandprivacy@okotoks.ca)*