

NATIONAL COMMUNITY COMMITTEE  
**INDIVIDUALS with DISABILITIES**  
**SUBCOMMITTEE**



**SECTION D: VERIFICATION OF DISABILITY**

This form is to be completed by a health professional, such as a doctor, practice nurse, occupational therapist, etc.  
**PLEASE USE A BLACK INK PEN AS WE HAVE TO PHOTOCOPY THIS FORM**

This is to certify that

Applicant's full name

Has the following disability

How long do you estimate the applicant's period of incapacity will last?

What aids, if any, does the applicant use for mobility?

**In your opinion, how far can the applicant walk, with or without aids? (Please tick one)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cannot get out of the house | <input type="checkbox"/> Can only reach the letterbox | <input type="checkbox"/> Up to 50 metres  |
| <input type="checkbox"/> Up to 100 metres            | <input type="checkbox"/> Up to 200 metres             | <input type="checkbox"/> Up to 500 metres |
| <input type="checkbox"/> Over 500 metres             | <input type="checkbox"/> Fully mobile                 |   |

**The applicant's need for help with mobility is (Please tick one)**

- |                                    |                                    |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Essential | <input type="checkbox"/> Desirable |
|------------------------------------|------------------------------------|

**Comments**

Please use this space to add any information you believe would be useful for us to know when assessing this grant application *(Please continue on a separate sheet if necessary.)*

**Health Professional Details**

First name

Last name

Postal Address

City/Town

Daytime phone number

Your occupation

Signed

Date

 / / (day / month / year)