

**FOR OFFICE USE ONLY**

Date Received:	Date Card Issued:	Call For Photo <input type="checkbox"/>	Card #:	References Verified <input type="checkbox"/>
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# PAL Card Application Form

**Please complete the following information. All information pertaining to this application is confidential.**

Name of PAL Card Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
dd / mm / yy

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Postal Code: \_\_\_\_\_

City: \_\_\_\_\_ Email: \_\_\_\_\_

**If form completed by someone other than applicant, please provide:**

Name: \_\_\_\_\_ Agency if applicable: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Contact Email: \_\_\_\_\_

Signature: \_\_\_\_\_

I request a Braille label on my Card

**To determine eligibility requirements, please answer the following questions:**

1. Is the disability:  Permanent  If Temporary, please indicate length of time assistance is required

\_\_\_\_\_

2. Can your disability be corrected with the use of an assistive device? (eg. Eyeglasses):

Yes  No

Please explain:

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**No medical certificate or letter required for PAL Card eligibility.**

**Please fill in the references sections on the back of this application.**

The references must be people who know that the applicant meets the criteria: for example, agency or service provider, occupational or physiotherapist, teacher, etc. All references will be contacted by staff before the PAL Card application is approved. Please do not include friends or relatives as references.

## References:

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1. Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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2. Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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**If your application for a PAL Card is successful, we will be required to take a photograph of you. You will be contacted to arrange a time for your picture to be taken.**

The statements made above are, to the best of my knowledge, complete and accurate. I understand that a staff person will contact the references and that approval of this application depends upon verification that the applicant is a person with a disability who requires a support person to participate in or perform recreation/leisure activities.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of Applicant, Parent, Guardian, or Caregiver)

### Mail or Drop off completed application form to:

#### 18 AND YOUNGER:

Community Services Department  
Attn: PAL Card – Sarah Smart  
111 Syndicate Ave South  
Thunder Bay, ON P7E 6S4  
**OR** fax to 625-3395.

For more information or assistance  
contact Sarah at 625-3220 or  
ssmart@thunderbay.ca

#### 19 AND OLDER:

Canada Games Complex  
Attn: PAL Card – Darrik Smith  
420 Winnipeg Avenue  
Thunder Bay, ON P7B 6B7  
**OR** fax to 345-4520.

For more information or assistance  
contact Darrik at 684-3338 or  
dsmith@thunderbay.ca

## Definition of Disability according to Statistics Canada

### **Disability:**

*Activity limitations experienced by individuals as a result of physical or mental conditions or health problems; the impact these limitations have on day-to-day life; help used or needed as a result of limitations, including specialized equipment and aids.*

**Personal information** on this form is collected under the authority of the Municipal Act, R.S.O. 1980, c.302 (as amended) and will be used within the programme for emergency contact and program follow-up. Questions regarding this collection should be directed to the Supervisor Community Partnerships, 111 S. Syndicate Avenue, Thunder Bay, Ontario, P7E 6S4, 625-2419.