
# MOBILITY IMPAIRED SEATING APPLICATION FORM SEASON 2019-20

SACA has mobility impaired seating (including wheelchair spaces) available for Members who require these spaces.

Seats are limited and Members wanting to reserve mobility impaired seating or wheelchair spaces during Cricket Australia International cricket matches are required to complete this form and submit to SACA Member Services.

Once approved, Members will be sent a Mobility Impaired Seat Request Form to select match dates and seats. Guests/carers must have access to the venue and Members' Area via their own Member Card, Transferable Associate Card or Guest Pass (on selected match days). There is a strict limit of **two reserved seats** per Member.

**Please return this form to membership@saca.com.au or SACA Member Services, Po Box 545, SA 5006 by Friday 2 August 2019.**

## MOBILITY IMPAIRED SEATING APPLICATION

| | |
|---|---|
| **Member Number** | |
| **Member Name** | |
| **Postal Address** | |
| **Contact Number** | |
| **Email Address** | |

I understand that the allocated seating is strictly non-transferrable. Mobility impaired seating is limited and requests will be processed as they are received until allocation is exhausted.

**Signed by SACA Member:** _____ **Date:** _____

**The following section is to be completed and signed by the SACA Members' Medical Professional.**

☐ I have assessed the below mentioned patient and can confirm the following details:

**Name of SACA Member:** _____ **Date of Birth:** _____

The Member has a mobility impairment that will require them to apply for mobility impaired seating.

**Please provide details of the Member's specific accessible seating requirements to assist with seat allocation.**

☐ Unable to negotiate steps ☐ Wheelchair required ☐ Assistance Dog required

☐ Electric Mobility Scooter required ☐ Mobility Aid required ☐ Visually impaired cain

Other details: _____

**Is the Member's mobility impairment a permanent impairment?** ☐ No ☐ Yes

**Name of Medical Professional:** _____

**Address of Medical Practice:** _____

**Signed by Medical Professional:** _____ **Date:** _____

**SOUTH AUSTRALIAN CRICKET ASSOCIATION LTD.**
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