

PART A – GENERAL INFORMATION

PASSENGER # _____
Date Entered _____

1. First Name: _____ Middle Initial(s) _____
Last Name: _____
2. Birth date (YY/MM/DD): _____ 4. Gender: Male Female
4. Municipal/ Street Address: _____ Apt. #: _____
City: _____ Postal Code: _____
5. Mailing Address (if different from above): _____
City: _____ Prov: _____ Postal Code: _____
6. Phone (daytime): _____ (evening): _____
- 7: E-mail: _____ Would you like e-mail updates? Yes No

8. Emergency Contacts

- a) Name: _____ Relationship to applicant: _____
Phone (daytime) : _____ (evening) : _____
- b) Name: _____ Relationship to applicant: _____
Phone (daytime) : _____ (evening) : _____
9. Alternate drop address: _____
Contact person: _____ Phone: _____

PART B - DISABILITY AND MOBILITY EQUIPMENT INFORMATION

10. Primary reason for using service: Medical Disability Other (CHECK ONE)
If other, please describe: _____
11. Please describe any disability and/or health condition affecting your mobility: _____

12. If this is a temporary disability or health condition, when do you months expect it to prevent you from using regular transit/transportation? _____ (e.g. Jan 2012)

13. Do you require an attendant when you travel? Yes No Occasionally

14. Do you use any of these mobility aids or equipment? (CHECK ALL THAT APPLY)

- | | | |
|---|---------------------------------------|--|
| <input type="radio"/> cane | <input type="radio"/> prosthesis | <input type="radio"/> powered wheelchair |
| <input type="radio"/> crutches | <input type="radio"/> powered scooter | <input type="radio"/> manual wheelchair |
| <input type="radio"/> walker | <input type="radio"/> white cane | <input type="radio"/> portable oxygen |
| <input type="radio"/> leg brace(s) | <input type="radio"/> guide dog | <input type="radio"/> Child/car seat |
| <input type="radio"/> other (please list) | | |
-

15. If you use a wheel chair, are you able to transfer to a seat in the vehicle? Yes No

16. Do you require any special or life- sustaining medication? Yes No

If yes, please describe : _____

17. **Do you have any allergies?** Yes No (i.e.: medication, food, insects, etc)

If yes, please describe : _____

18. Do you experience seizures? Yes No

Please explain type and how they are handled: _____

19. Please provide any additional information you believe may be relevant: _____

I certify that the above information is accurate and complete:

Signature

Date(YY/MM/DD)

Or person completing form on behalf of passenger:

Name: _____

Relationship to applicant: _____ Daytime Phone: _____