Rocky View Regional Handibus Society
Transportation for Community Needs

Tel: 403-948-2887 Toll Free: 1-877-389-2887
P.O. Box 10203, Airdrie, AB T4A 0H5
www.rockyviewbus.ca

Return form to: office@rockyviewbus.ca
or fax to 403-398-0494

Office use:
PASSENGER #________
Date Entered ________

PART A – GENERAL INFORMATION

1. First Name: ___________________________________ Middle Initial(s)______________________

   Last Name: ____

2. Birth date (YY/MM/DD): ___________________ 3. Gender: ❍ Male ❍ Female ❍ N/A

4. Municipal/ Street Address: _______________________________________ Apt. #:______________

   City: _______________________________________ Postal Code: _______________________

5. Mailing Address (*if different from above*): ____

   City: ____ Prov: _______ Postal Code: ___________

6. Phone (*cell*): ___________________________ (*landline*): ____________________________

7: E-mail: ____________________________

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 barrier (CHECK ONE)

If other, please describe: ____

11. Please describe any disability and/or health condition affecting our ability to provide a safe comfortable journey:

____

____

____

The information collected is solely for use by Rocky View Regional Handibus. Personal information will not be given out to other organizations. Aggregate data may be used for reporting requirements.

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

❍ cane ❍ prosthesis ❍ powered wheelchair
❍ crutches ❍ powered scooter ❍ manual wheelchair
❍ walker ❍ portable oxygen ❍ large wheelchair
❍ guide dog ❍ child/car seat (height ______cm Weight ______kg)

❍ other ____

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

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

If yes, please describe:____

15. **Do you have life-threatening allergies?** ❍ Yes ❍ No (i.e. medication, food, insects, etc)

If yes, please describe:

____

16. Do you experience seizures? ❍ Yes ❍ No

Please explain type and how they are handled:

____

____

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

____

____

____

____

____

Verification of Information:

The person named below is the customer making this application or a person duly authorized to make this application. This person verifies that the information provided in this application and any supporting documents is true and accurate.

Name: ____ Date:________________

Relationship to applicant: ____________________________ Daytime Phone: _________________
(*if not the applicant*)

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