

Rocky View Regional Handibus Society

Transportation for Community Needs

P.O. Box 3235, Airdrie, AB T4B 2B5
Tel: (403) 948-2887 Fax: (403) 948-2802
www.rockyviewbus.ca

PART A – GENERAL INFORMATION

PASSENGER # _____
Date Entered _____

1. Mr. Mrs. Ms. (CIRCLE ONE)
2. First Name: _____ Middle Initial: _____
Last Name: _____
3. Birth date (YY/MM/DD): _____
4. Gender: Male Female (CIRCLE ONE)
5. Street Address: _____ Apt. #: _____
City: _____ Postal Code: _____
6. Phone (DAYTIME): _____ (EVENING): _____
7. E-mail: _____
8. Mailing Address (IF DIFFERENT FROM ABOVE): _____
City: _____ Postal Code: _____
9. **Emergency Contacts**
 - a) Name: _____ Relationship to applicant: _____
Phone (daytime): _____ (evening): _____
 - b) Name: _____ Relationship to applicant: _____
Phone (daytime): _____ (evening): _____
10. Alternate drop address: _____
Contact person: _____ Phone: _____

PART B - DISABILITY AND MOBILITY EQUIPMENT INFORMATION

11. Primary reason for using service: ___Medical ___Disability ___Other (CHECK ONE)
If other, please describe: _____
12. Please describe any disability and/or health condition affecting your mobility: _____

13. If this is a temporary disability or health condition, how long do you expect it to prevent you from using regular transit/transportation? _____ months

The information collected will 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.

14. Do you require an attendant when you travel? Yes No Occasionally (CIRCLE ONE)

15. 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) | | |
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16. If you use a wheel chair, are you able to transfer to a seat? Yes No (CIRCLE ONE)

17. Do you require any special medication? Yes No (CIRCLE ONE)

If yes, please describe _____

18. **Do you have any allergies?** Yes No (i.e.: MEDICATION, FOOD, INSECTS, ETC)

If yes, please describe _____

19. Do you experience seizures? Yes No (CIRCLE ONE)

Please explain type and how they are handled: _____

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

I certify that the above information is accurate and complete:

Signature _____ Date _____

Or person completing form:

Name: _____

Relationship to applicant: _____ Daytime Phone: _____

Would you like e-mail updates? Yes No (CIRCLE ONE)