Rocky View Regional Handibus Society
Transportation for Community Needs

P.O Box 10203, Airdrie, AB T4A 0H5
Tel: (403) 948-2887 Fax: (403) 948-2802
www.rockyviewbus.ca

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 expect to return to using regular transit/transportation? _____ (e.g. Jan, 2017)

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.

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)

❍ cane	❍ prosthesis	❍ powered wheelchair
❍ crutches	❍ powered scooter	❍ manual wheelchair
❍ walker	❍ white cane	❍ portable oxygen
❍ leg brace(s)	❍ guide dog	❍ Child/car seat

❍ 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: _____

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