REGISTRATION FORM – COMMUNITY TRANSPORTATION

PASSENGER INFORMATION

SECTION A

PLEASE PRINT CLEARLY

_____ _____ ____ ____ ____ ____

Surname First Name Mr. Mrs. Miss Ms.

_____ ____ ____ ____

Street Name and Number Apt. Suite Unit

_____ _____

Town or Village Postal Code

_____

Residence Address (if not the same as mailing address)

_____ _____ _____

Date (dd/mm/yy) Home Number Business Number

_____ _____

Signature Date of Birth (dd/mm/yy)

_____ _____

Contact Person (in case of emergency) Contact's Telephone Number

Do you have any mobility restrictions? Yes _____ No _____

Is your disability: (a) temporary _____ (b) permanent _____

Are you confined to a wheelchair? Yes _____ No _____

If confined to a wheelchair, is your residence ramped? Yes _____ No _____

If you are not using a wheelchair, do you use any aids to assist you in walking, please specify? (e.g. cane, walker, crutches, etc.) _____

Please list three (3) frequent addresses that you will be transported to? (e.g. doctor, medical procedures, shopping).

_____ _____ _____

Please provide name, address, and telephone number of your attending physician. (if you are completing Section B)

_____

Return to: Town of New Tecumseth, P.O. Box 910, 10 Wellington St. E., Alliston, Ont. L9R 1A1

ELIGIBILITY FORM – ACCESSIBILITY TRANSPORTATION

INFORMATION FROM PHYSICIAN

SECTION B (only required if applying for special accessibility transportation)

**** THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR ATTENDING PHYSICIAN BEFORE YOU MAY BE CONSIDERED ELIGIBLE FOR SPECIALIZED TRANSPORTATION. ****

ATTENTION: PHYSICIAN

Your patient has applied to The Town of New Tecumseth for use of this service. Using the following Ontario Ministry of Transportation Eligibility Criteria; the provision of transportation for physically disabled persons is intended to provide service to those individuals who, regardless of age, are unable to board conventional transit vehicles, or walk 175 meters. Please advise us of the nature of your patients' disability that would enable him/her to meet the criteria.

***** PLEASE PRINT *****

_____

_____

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_____

In your opinion is this patient able to use conventional transportation?

Yes _____ No _____

PHYSICIAN NAME _____
(please print or stamp)

OFFICE ADDRESS _____

OFFICE TELEPHONE _____

PHYSICIAN SIGNATURE _____ Date: _____
(dd/mm/yy)