REGIONAL TRANSPORTATION SERVICE – BROOKS TO MEDICINE HAT PILOT PROJECT APPLICATION FORM

APPLICANT INFORMATION

Name (full):		Gender:
Date of birth:		Phone:
Current address:		
City:	Province:	Postal Code:

EMERGENCY CONTACT

Name:		
Address:		Phone:
City:	Province:	Alt Phone:
Relationship to Applicant:		Postal Code:

ALTERNATE EMERGENCY CONTACT

Name:		
Address:		Phone:
City:	Province:	Alt Phone:
Relationship to Applicant:		Postal Code:

MEDICAL INFORMATION

Doctor's Name:	Phone:
Address:	Fax:

Please have a medical practitioner complete the Regional Transportation Service Medical Application Form and attach it to this application.

CLIENT QUESTIONAIRE

How often will you be utilizing the Service?

Recurring Booking: Yes: _____ No: ______ Occasionally: Yes: ____ No: ____ Rarely: Yes: ____ No: ____

What mobility aides do you use when travelling? Please check all that apply, your answers will ensure the appropriate specialized service will be provided.

☐ None	☐ Cane
☐ Walker- non-collapsible	☐ Walker-Collapsible
☐ Manual Wheelchair	☐ Electric Wheelchair
☐ Scooter	☐ Service Animal
☐ Oxygen	☐ Other:______________

Please Note: If a wheelchair or scooter is used, the maximum base dimensions are 30" x 50" (76x127cm). Equipment larger than this cannot be accommodated. A combined weight of the equipment and the passenger cannot exceed 750 lbs. (340 kg).

Does the outside dimensions of the wheelchair/scooter exceed these measurements? Yes:__________ No:__________

Does the combined weight of the passenger and mobility device exceed this weight? Yes:__________ No:__________

If yes to either, please explain:____

____

____.

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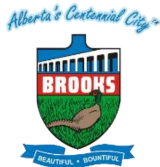
Can you recognize landmarks? Yes: _____ No: _____. If NO, please explain:____ ____ ____.		
CLIENT QUESTIONAIRE CONTINUED		
Will you require a mandatory attendant when using the Service? Yes: _____ No: _____.		
Will your home address be your primary pick up point? Yes: _____ No: _____. If NO, please provide your alternate address below, so we may add it to our files.		
Address:		Phone:
City:	Province:	Postal Code:
AUTHORITY		
I HEREBY CERTIFY THAT I HAVE REVIEWED THE INFORMATION PROVIDED AND CERTIFY IT TO BE TRUE. I GIVE PERMISSION FOR THE REGIONAL TRANSPORATION SERVICE TO CONTACT MY AUTHENTICATOR TO VERIFY THE NEED FOR MY REQUEST.		
Signature of applicant:		Date:
If someone else has completed this form on behalf of the applicant, please provide the following:		
Name:	Relationship to Applicant:	
Signature		Date:



This information is being collected for the purpose of establishing and operating the Regional Transportation Service – Brooks to Medicine Hat Pilot Project pursuant to Section 33 (C) of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, you may contact the City of Brooks FOIP Coordinator at 403-362-3333.