

# Rocky View Regional Handibus Society

*Transportation for Community Needs*

Tel: 403-948-2887 Toll Free: 1-887-389-2887  
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:

<b>PASSENGER #</b> _____
<b>Date Entered</b> _____

## 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:

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12. 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"/> portable oxygen                                  | <input type="radio"/> large wheelchair   |
| <input type="radio"/> guide dog | <input type="radio"/> 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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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### 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)

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.