# Rocky View Regional Handibus Society
*Transportation for Community Needs*

**Tel: 403-948-2887 Toll Free: 1-877-389-2887**
**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:

**PASSENGER #________**
**Date Entered ________**

## 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:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

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.

12. Do you use any of these mobility aids or equipment? (CHECK ALL THAT APPLY)

❍ cane
❍ crutches
❍ walker
❍ guide dog
❍ prosthesis
❍ powered scooter
❍ portable oxygen
❍ child/car seat (height ______cm Weight ______kg)
❍ powered wheelchair
❍ manual wheelchair
❍ large wheelchair

❍ 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:

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

---

## 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.