

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:

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:

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.