MOBILITY BUS SERVICE APPLICATION AND SUPPORT PERSON

APPLICANT INFORMATION:

Name: _____
(Last) (First) (Middle)

Address: _____
(Number) (Street) (Apt)

_____
(City) (Postal Code)

Daytime Phone: _____ Evening Phone: _____ TTY Number: _____

E-Mail: _____

Do you use: (Please check all that apply) ☐ Wheelchair ☐ Walker ☐ Scooter ☐ Cart ☐ Crutches
☐ Cane ☐ Other _____

Regarding fixed route transit service – bus stops – please check one box:

☐ I Can usually get to and from a regular transit stop without assistance.
☐ I can get to and from a regular transit stop **only if** (circle all that apply and fill in the blanks as required):

1. I have an attendant with me.
2. I need to travel less than an average city block.
3. I receive travel training
4. The path is Free of ice and snow.
5. Other _____

☐ I can never get to and from a regular transit bus stop. (Please explain why)

_____
_____

The REQUEST FOR PROFESSIONAL CERTIFICATION must be filled out by an appropriate health care professional.

If your disability prevents you from using the City Of Belleville regular fixed-route transit service, one of the following health care professionals, as appropriate to your case, may complete the professional certification part of this application form. **Licensed physician, Registered occupational therapist, Licensed physical therapist, Certified psychologist/psychiatrist, Licensed optometrist/ophthalmologist/eye physician, Registered Nurse.**

APPLICANT DECLARATION

I hereby certify that to the best of my knowledge, the information given above is correct. I authorize the release of medical information to the City Of Belleville. I consent to the contents of my application and eligibility for specialized transit services discussed with the health care professional that completed part of this application.

Signature of Applicant or Designate: _____ Date: _____

PROFESSIONAL CERTIFICATION- TO BE COMPLETED BY A HEATH CARE PROFESSIONAL

You are being asked by the applicant to provide information regarding his/her ability to make use of public transit and their need for a support person to travel with them. The information you provide will allow us to evaluate the request and to provide the appropriate service. Thank you for your co-operation in this matter. If you have any questions, you may call Tammy Thompson at 613-962-1925.

I have read the form in its entirety Yes ☐ No ☐

Please describe how the disability affects the applicants ability to use transit service and if a support person is required to assist with travel.

_____
_____
_____

It is my professional opinion that the applicant has a disability that: (Check the one box that best explains the applicant's ability to use public transit.)

☐ Prevents them from using public transit without the aid of a support person
☐ Does not prevent them from using public transit without the aid of a support person.
☐ Specific training (ie travel training) would allow them to use public transit without the assistance of a support person.
☐ Other: (Please explain)

_____
_____

Is the disability permanent? Yes No If Temporary for how long? _____

_____ _____
Signature of Health Care Professional Date

_____ _____
Print Name Profession

Personal information on this form is collected under the authority of the Municipal Freedom of Information and Privacy Protection Act and will be used to assess the individual's qualifications for the Mobility Bus Service and will remain confidential.

The application will be assessed by the City Of Belleville Transit Services. If you have any questions about your application please call 613-962-4344 extension 3550.

The completed application is to be returned to
The City of Belleville, Transit Services
400 Coleman Street
Belleville, ON K8P 3J4