

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 QUESTIONNAIRE

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.

<input type="checkbox"/> None <input type="checkbox"/> Walker- non-collapsible <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Scooter <input type="checkbox"/> Oxygen	<input type="checkbox"/> Cane <input type="checkbox"/> Walker-Collapsible <input type="checkbox"/> Electric Wheelchair <input type="checkbox"/> Service Animal <input type="checkbox"/> Other: _____
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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 QUESTIONNAIRE 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:

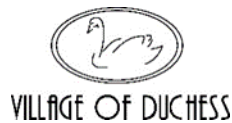
AUTHORITY

I HEREBY CERTIFY THAT I HAVE REVIEWED THE INFORMATION PROVIDED AND CERTIFY IT TO BE TRUE. I GIVE PERMISSION FOR THE REGIONAL TRANSPORTATION SERVICE TO CONTACT MY AUTHENTICATOR TO VERIFY THE NEED FOR MY REQUEST.

Signature of applicant:	Date:
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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.

Regional Transportation Service Application Form - Medical

To Be Completed By A Health Care Professional (in the event you are utilizing the transportation service for non-medical needs, please continue to the waiver portion of this Form).

The Regional Transportation Service – Brooks to Medicine Hat Pilot Project is a service that is providing transportation services for residents within the Newell Region who are in need of service to Medicine Hat (specifically those in need of medical services).

In order to ensure that Service resources are properly and effectively dedicated to the individuals it is intended to serve, it is necessary that applicants be carefully assessed to ensure the safety of both service driver and passenger.

For assistance or questions regarding the service, please call 403-362-3333.

**Any charges incurred during the process of completing these forms are the sole responsibility of the applicant.*

Applicant's Name _____
Last First Middle

1. I have read and understood the guidelines. Yes No
2. I agree with the information provided in the application. Yes No

If you answered **NO**, please explain: _____

3. Are there any health condition(s) or disability that prevents the applicant from using the transit service?

4. Severity of disability/limitations: Mild Moderate Severe Profound

5. Expected duration of disability: Temporary - Expected duration: ____/____/____
YYYY MM DD

- Permanent - No expectation of improvement
Seasonal - Use of regular transit impacted by winter ice and snow conditions (Approx. Oct. - Apr.)

6. Does the applicant require an attendant when riding the Handibus? Yes No

Service drivers must concentrate on the safe operation of their vehicles and cannot supervise those who require constant and frequent attention for medical or behavioral reasons. Registrants requiring attention of this nature, or who display behavior unacceptable to other passengers, will be required to ride with an attendant at all times. If the applicant requires a mandatory attendant, Handibus will only provide service when an attendant travels with the applicant at all times.

7. Can the applicant be left alone at his/her destination? Yes No

8. Can the applicant be left alone at home? Yes No

9. Are there any additional health concerns (i.e. behavioural, aggression, seizure) that the Service should be made aware of?

I hereby certify that the information included in this assessment is accurate and a true reflection of the applicant’s ability to use alternative forms of transit.

Signature: _____

Date _____/_____/_____

 YYYY MM DD

Address _____

Unit and Bldg. No. Street

City Prov. Postal Code

Phone (____)_____ License/Certification No:_____.

Professional designation: Licensed Physical Therapist Nurse
 Certified Rehabilitation Specialist Licensed Optometrist
 Registered Occupational Therapist Certified Psychologist
 Other:_____

With permission from the applicant, the Health Care Professional who verifies this form can also forward this completed application to: Regional Transportation Service Registration, Box 879, 201-1st Avenue West | Brooks AB T1R 1B7; or fax to (403) 362-4787.

Regional Transportation Service – Medical Waiver and Release Form (waiver for non-medical travel).

In consideration of the acceptance of my participation with the Regional Transportation Service, Brooks to Medicine Hat transportation Project (the "Project"), riding in its vehicles and all of the Projects related activities, I agree to the following:

1. I hereby agree to comply with the rules and policies stated within the Regional Transportation Services, Brooks to Medicine Hat Project Guide Book.
2. For myself, my executors, my administrators, my heirs, my next of kin, my successors, my assignees, I HEREBY:
 - a) Waive and release any and all claims that I may have against the City of Brooks, County of Newell, Village of Rosemary, Village of Duchess and Town of Bassano (the "Organizers") their committees, officers, directors, members, volunteers, employees, agents, sponsors or their successors and assignees, including any and all claims for damages caused by negligence of any of them, arising out of my participation in the Project, riding in its vehicles and participating in any of the Project's activities or related events, together with any costs, including attorneys' fees, that may be incurred as a result of any such claim whether valid or not, and;
 - b) Indemnify and hold harmless and release each of the Organizers against and from any such claims, that I or my executors, heirs or assignees may have or assert and against them and any costs they may have including attorney's fees with respect thereto.
3. I hereby acknowledge that I have sole responsibility for my personal health during my involvement in any Project related activities.
4. I hereby acknowledge that participation in the Project carries with it inherent risks and potential hazards. I therefore release the Organizers, the Project committee, their officers, directors, members, volunteers, employees, sponsors, of any liability resulting from injury or death during my involvement with the Project and its related activities.
5. I hereby attest and verify that I am physically fit and that my physical condition does not prevent me from participating in the Project and this has been verified by a licensed medical doctor.

6. The Organizer is not responsible for any injuries sustained by me during my involvement with the Project or any of its activities and I hereby consent and authorize the Organizer to seek medical assistance and to administer medical treatment, which may be deemed advisable in the event of injury, accident, and or illness during the Project.

All participants (and if applicable, parent or guardian) accessing this service for non medical needs who have not had a qualified Health Care Professional complete sections 1 – 9 of the application form, must sign the waiver and release form in order to access the service.

Date

Signature of Participant

Print Name of Participant

Witness

Parent/ guardian's signature (if under 18 years)