Regional Transportation Service Application Form - Medical

To Be Completed By A Health Care Professional

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 ___________________________________________________________________________

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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: _____/_____/_____

   □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
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 ________________________________
                           Street
                        ________________________________
City  Provi.  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.