

APPLICATION FOR MOBILITY SERVICES

Guelph Transit, 59 Carden Street, Guelph, ON, N1H 3A1, Tel: 822-1811, Fax: 822-5549



Individuals will be eligible for our service **only if they are physically unable to:**

- **climb or descent steps used on a conventional bus**
- **walk a distance of 175 metres**
- **use conventional transit**

Registration # _____

Name of Applicant: _____
Surname (please print) Mr/Miss/Mrs/Ms First Name Initial

Address: _____
Street Number and Name Apt #

City/Town: _____ Postal Code: _____ Phone: _____

Date of Birth: _____
Day Month Year

Do you use a wheelchair? Yes No Three-wheeled scooter? Yes No Walker? Yes No

Other? (describe) _____

- If yes, a) Does your home have a ramp Yes No
b) Does your wheelchair/scooter have a lap belt? Yes No
c) Are you able to ride a regular bus? Yes No

What is your disability that prevents you from using public transit? _____

How often will you use the service? _____

Next of kin: Name _____ Phone Number _____

Relationship _____

I consent to the City of Guelph contacting my health care professional if additional information or clarification is required regarding my disability and my application.

Date: _____ Applicant's Signature: _____

TO BE FILLED OUT BY PHYSICIAN (please print)

Eligibility Criteria: unable to climb or descent steps used on a conventional bus; walk a distance of 175 metres

_____ is eligible for Mobility Services due to the following:
Name of applicant

- is physically unable to climb/descend steps of Public Transit
- is physically unable to walk a distance of 175 metres

This person requires Mobility Services on a temporary basis:

- due to a temporary disability (i.e. fractured limbs)
- for winter months (November 15 to March 15), as the extreme cold, ice and snow prevents this person from walking 175 metres

Please identify the disability _____
(individuals will be eligible for our service **only if** they have a physical disability which prevents them from using city buses.)

Are there other conditions or factors which would prevent the applicant's safe use of conventional transit?

Yes No If yes, comment: _____

Does the applicant use a mobility aid? Yes No If yes, identify: _____

Does this applicant require a temporary registration? If she/he requires temporary registration only, please estimate the required time period in months. _____

Permanent Temporary: number of months

Doctor's Name _____ Doctor's Signature _____

Phone: _____