Transportation Services Registration Form

Date: _____

1. **–Primary Information**

Last Name:	First Name:
Physical Address:	Apt #
Name of Residence (if applicable):	
Primary Phone #:	Secondary Phone #:
Mailing Address (if different):	
Gender: Male □ Female□	Date of Birth: ____/____/____ Year/Month/Day

2. – Which mobility and/or medical aids (if any) do you use regularly?

☐ Walker (Folding ☐ Non-Folding ☐) ☐ Manual Wheelchair*
☐ Cane ☐ Motorized Wheel Chair*
☐ Crutches ☐ Three-wheel/four-wheel scooter
☐ Personal Care Attendants
* For safety reasons, all wheelchairs (manual or motorized) must come equipped with four anchoring devices for secure attachment to paratransit vehicle floor.

3. **– Destination(s) for transportation services**

_____
_____
_____

4 – Emergency Contact #1

Last Name:	First Name:
Home Phone #:	Work #:
Cell#:	Relation to Applicant:

5 – Emergency Contact #2

Last Name:	First Name:
Home Phone #:	Work #:
Cell#:	Relation to Applicant:

Any other issues we need to be made aware of: _____

PICK-UP INFORMATION

Does your home have a ramp? _____yes _____no
Can client be left alone at home? _____ yes _____no
Is client independent? _____yes _____no
Example: (Is client able to book own transportation, change or cancel the bus).
Is there any concern with walking up/down the bus or destination stairs? ___yes ___no
Does the client need/require epi-pen? _____yes _____no
Drivers are not permitted to assist passengers with medication!

Check all impairments and or medical factors that apply:

___Motor, __Speech, ___Hearing, ___Visual, ___Intellectual, ___Psychological

Check all that apply:

___Alzheimer's - Early or Advanced
___Dementia
___Cognitive Impairment
___Severe Allergies
___Colonoscopy Bag
___ Anxiety Disorder
___ Prone to Seizures
___ Prone to Verbal Outbursts
___ Non-Verbal: Signs of Distress _____

Other: _____
_____

Program Information:

Program: _____

Estimated Pick up time for Program: _____

Regular Schedule: _____

Start Date: _____

End Date: _____

BILLING INFORMATION

Medical Trips: _____ Cash _____Account
If account whom should it be bill to: _____
_____

Charters: _____Cash _____Account
If account whom should it be bill to: _____
_____

Other: _____Cash _____Account
If account whom should it be bill to: _____
_____

GENERAL POLICIES

1. Drivers are required to transport riders to the pre-reserved destination indicated on the driver's trip schedule. Drivers are not allowed to make any destination changes.
2. Drivers are prohibited from entering a rider's residence for any reason.
3. Riders are required to wear seatbelts while on the bus. Drivers can provide assistance with seat belts with permission from the rider.
4. Smoking, eating, or drinking is NOT allowed while onboard a Selkirk Mobility vehicle.

I do hereby acknowledge that this registration form is filled out to the best of my ability and knowledge.

_____ _____
Signature of Participant, Parent or Guardian Date

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selkirkmobility@outlook.com