Sault Ste. Marie Parabus
111 Huron Street
Sault Ste. Marie, Ontario P6A 5P9
Tel: (705) 942-1404 Fax: (705) 759-5834

APPLICATION FOR ELIGIBILITY

SECTION "A" To be completed by the Applicant, Family, or Legal Guadian

NAME: _____

ADDRESS:_____APT#:_____POSTAL CODE:_____

DATE OF BIRTH: (MM/DD/YY)_____/_____/_____ GENDER: MALE ☐ FEMALE ☐ OTHER ☐

MOBILE: _____ HOME: _____

EMAIL ADDRESS:_____

Preferred Method of Communication: PHONE ☐ E-MAIL ☐ LETTER ☐

Preferred Method of Communication in the event of a Service Delay of over 30 minutes:
PHONE ☐ TEXT ☐

DIRECTION FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize you (the physician) to release any medical information which may be required by an official of Transit Services to aid in determining my eligibility for Parabus service in this community.

_____
Signature of Applicant

SECTION "B" To be completed by a Physician/Nurse Practitioner/Chiropractor/ Occupational Therapist/Physiotherapist

1) Describe how the disability prevents the applicant from using conventional transit.

Applicant Name: _____

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2) Are there any other conditions or factors that would prevent the applicant's safe use of conventional transit?

3) Applicant is applying for:

a) Permanent ☐

b) Conditional ☐

Please provide details(i.e. Seasonal, weather) _____

c) Temporary: 3 months ☐ 6 months ☐ 12 months ☐

Please circle YES or NO for each of the following questions:

4) Is the applicant physically able to walk 175 m? (An average city block) ☐ **YES** ☐ **NO**

5) Will the applicant require an assistant while travelling on the Parabus?*** ☐ **YES** ☐ **NO**

****** If YES, then see instructions in Parabus brochure for more information on obtaining a Parabus Client Transit Card which will allow an attendant to ride for FREE.***

6) Does the applicant use a mobility aid? (please check all that apply)

a) none ☐ b) walker ☐ c) cane ☐ d) crutches ☐

e) manual wheelchair ☐ f) electric wheelchair ☐ g) scooter ☐ h) white cane ☐

i) Other (please specify): _____

DATE:

PHYSICIAN'S NAME:_____

PHYSICIAN'S SIGNATURE:_____

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OFFICE SPACE ONLY

DATE APPROVED: TEMPORARY: (Expiry Date)

Revised: April 2020