SAULT STE. MARIE

Sault Ste. Marie Parabus Application

111 Huron Street, Sault Ste. Marie, Ontario, P6A 5P9

Tel: (705) 942-1404 Fax: (705) 759-5834

Section "A" To be completed by the Applicant, Family, or Legal Guardian

Name of Applicant: _____

Address: _____ Apartment #: _____ Postal Code: _____

Date of Birth (mm/dd/yy): _____

Mobile Phone: _____ Home Phone: _____

Email Address: _____

Preferred Method of Communication: Phone ☐ Email ☐ 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 or designated professional) 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 the community.

Signature of applicant:

_____

Section "B" To be completed by a Physician/Nurse Practitioner/Chiropractor/Occupational Therapist/Physiotherapist/Optometrist or Ophthalmologist:

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

_____

_____

2) Does the applicant have vision loss that affects their ability to use conventional transit?

_____

Applicant Name: _____

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

_____

4) Applicant is applying for (Check one box):

Permanent ☐ Conditional ☐ Temporary ☐

Please provide details for conditional or temporary approval above (i.e. seasonal, weather):

_____

Conditional or temporary approval for how long (Check one box)?

3 Months ☐ 6 Months ☐ 12 Months ☐

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

5) Is the applicant physically able to walk 175m (an average city block)? Yes ☐ No ☐

6) Will the applicant require an assistant while travelling on the Parabus? Yes ☐ No ☐

If YES to #6, you will be issued a support person card at no additional cost and your support person will need to accompany you on all trips with the Parabus.

7) Is the applicant blind or partially sighted? Yes ☐ No ☐

8) Does the applicant use a mobility aid? Please mark spaces that apply.

None ☐ Walker ☐ Cane ☐ Crutches ☐

Manual Wheelchair ☐ Power Wheelchair ☐ Scooter ☐

Other (Please specify):

Date: _____

Physician's Name: _____

Physician's Signature: _____

Please allow 5-7 business days for application processing.

Office Space Only

Date Approved: _____ **Temporary:** _____