# REGIONAL TRANSPORTATION SERVICE – BROOKS TO MEDICINE HAT PILOT PROJECT APPLICATION FORM

| APPLICANT INFORMATION | | |
|---|---|---|
| Name (full): | | Gender: |
| Date of birth: | | Phone: |
| Current address: | | |
| City: | Province: | Postal Code: |

| EMERGENCY CONTACT | | |
|---|---|---|
| Name: | | |
| Address: | | Phone: |
| City: | Province: | Alt Phone: |
| Relationship to Applicant: | | Postal Code: |

| ALTERNATE EMERGENCY CONTACT | | |
|---|---|---|
| Name: | | |
| Address: | | Phone: |
| City: | Province: | Alt Phone: |
| Relationship to Applicant: | | Postal Code: |

| MEDICAL INFORMATION | |
|---|---|
| Doctor's Name: | Phone: |
| Address: | Fax: |

*Please have a medical practitioner complete the Regional Transportation Service Medical Application Form and attach it to this application.*

**CLIENT QUESTIONAIRE**

How often will you be utilizing the Service?

Recurring Booking: Yes: _____ No: _____ Occasionally: Yes: ____ No: ____ Rarely: Yes: ____ No: ____

What mobility aides do you use when travelling? Please check all that apply, your answers will ensure the appropriate specialized service will be provided.

- ☐ None
- ☐ Walker- non-collapsible
- ☐ Manual Wheelchair
- ☐ Scooter
- ☐ Oxygen
- ☐ Cane
- ☐ Walker-Collapsible
- ☐ Electric Wheelchair
- ☐ Service Animal
- ☐ Other:_____

**Please Note**: If a wheelchair or scooter is used, the maximum base dimensions are 30" x 50" (76x127cm). Equipment larger than this cannot be accommodated. A combined weight of the equipment and the passenger cannot exceed 750 lbs. (340 kg).

Does the outside dimensions of the wheelchair/scooter exceed these measurements? Yes:_____ No:_____
Does the combined weight of the passenger and mobility device exceed this weight? Yes:_____ No:_____
If yes to either, please explain:_____

_____

_____.

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Can you recognize landmarks? Yes: _____ No: _____. If NO, please explain:_____

_____

_____.

**CLIENT QUESTIONAIRE CONTINUED**

Will you require a mandatory attendant when using the Service? Yes: _____ No: _____.

Will your home address be your primary pick up point? Yes: _____ No: _____. If NO, please provide your alternate address below, so we may add it to our files.

| | | |
|---|---|---|
| Address: | | Phone: |
| City: | Province: | Postal Code: |

**AUTHORITY**

I HEREBY CERTIFY THAT I HAVE REVIEWED THE INFORMATION PROVIDED AND CERTIFY IT TO BE TRUE. I GIVE PERMISSION FOR THE REGIONAL TRANSPORATION SERVICE TO CONTACT MY AUTHENTICATOR TO VERIFY THE NEED FOR MY REQUEST.

| | |
|---|---|
| Signature of applicant: | Date: |

If someone else has completed this form on behalf of the applicant, please provide the following:

| | |
|---|---|
| Name: | Relationship to Applicant: |
| Signature | Date: |

*This information is being collected for the purpose of establishing and operating the Regional Transportation Service – Brooks to Medicine Hat Pilot Project pursuant to Section 33 (C) of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, you may contact the City of Brooks FOIP Coordinator at 403-362-3333.*

# Regional Transportation Service Application Form - Medical

## To Be Completed By A Health Care Professional (in the event you are utilizing the transportation service for non-medical needs, please continue to the waiver portion of this Form).

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 _____
Last First Middle

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: _____/_____/_____
   YYYY MM DD
   ☐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

*Service drivers must concentrate on the safe operation of their vehicles and cannot supervise those who require constant and frequent attention for medical or behavioral reasons. Registrants requiring attention of this nature, or who display behavior unacceptable to other passengers, will be required to ride with an attendant at all times. If the applicant requires a mandatory attendant, Handibus will only provide service when an attendant travels with the applicant at all times.*

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 _____
Unit and Bldg. No. Street

_____
City Prov. 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.

# Regional Transportation Service – Medical Waiver and Release Form (waiver for non-medical travel).

In consideration of the acceptance of my participation with the Regional Transportation Service, Brooks to Medicine Hat transportation Project (the "Project"), riding in its vehicles and all of the Projects related activities, I agree to the following:

1. I hereby agree to comply with the rules and policies stated within the Regional Transportation Services, Brooks to Medicine Hat Project Guide Book.

2. For myself, my executors, my administrators, my heirs, my next of kin, my successors, my assignees, I HEREBY:

    a) Waive and release any and all claims that I may have against the City of Brooks, County of Newell, Village of Rosemary, Village of Duchess and Town of Bassano (the "Organizers") their committees, officers, directors, members, volunteers, employees, agents, sponsors or their successors and assignees, including any and all claims for damages caused by negligence of any of them, arising out of my participation in the Project, riding in its vehicles and participating in any of the Project's activities or related events, together with any costs, including attorneys' fees, that may be incurred as a result of any such claim whether valid or not, and;

    b) Indemnify and hold harmless and release each of the Organizers against and from any such claims, that I or my executors, heirs or assignees may have or assert and against them and any costs they may have including attorney's fees with respect thereto.

3. I hereby acknowledge that I have sole responsibility for my personal health during my involvement in any Project related activities.

4. I hereby acknowledge that participation in the Project carries with it inherent risks and potential hazards. I therefore release the Organizers, the Project committee, their officers, directors, members, volunteers, employees, sponsors, of any liability resulting from injury or death during my involvement with the Project and its related activities.

5. I hereby attest and verify that I am physically fit and that my physical condition does not prevent me from participating in the Project and this has been verified by a licensed medical doctor.

6. The Organizer is not responsible for any injuries sustained by me during my involvement with the Project or any of its activities and I hereby consent and authorize the Organizer to seek medical assistance and to administer medical treatment, which may be deemed advisable in the event of injury, accident, and or illness during the Project.

All participants (and if applicable, parent or guardian) accessing this service for non medical needs who have not had a qualified Health Care Professional complete sections 1 – 9 of the application form, must sign the waiver and release form in order to access the service.

_____ _____

Date Signature of Participant

_____

Print Name of Participant

_____ _____

Witness Parent/ guardian's signature (if under 18 years)