lebanon transit

ADA SHARED RIDE APPLICATION

1. NAME: _____ DATE: _____
2. ADDRESS: _____

   CITY _____ STATE: _____ ZIP: _____
3. HOME# _____ CELL # _____
4. BIRTHDATE: _____
5. LAST 4 DIGITS OF SOCIAL SECURITY #: _____
6. WHAT IS THE DISABILITY WHICH PREVENTS YOU FROM USING OUR FIXED ROUTE SERVICES?

   _____

   _____

   _____

   IS THE CONDITION TEMPORARY? _____ YES _____ NO
   IF YES, EXPECTED DISABILITY UNTIL: _____
7. HOW DOES THIS DISABILITY PREVENT YOU FROM USING OUR FIXED ROUTE SERVICES? PLEASE EXPLAIN COMPLETELY, USE ADDITIONAL PAPER IF NECESSARY.

   _____

   _____

   _____

   _____
8. ARE THERE ANY OTHER EFFECTS OF YOUR DISABILITY WHICH WE SHOULD BE MADE AWARE OF?

   _____

   _____

9. DO YOU USE ANY OF THE FOLLOWING AIDS FOR MOBILITY?

_____ CANE	_____ CRUTCHES	_____ GUIDE DOG
_____ MANUAL WHEELCHAIR	_____ ELECTRIC WHEELCHAIR	

10. DO YOU REQUIRE A PERSONAL CARE ATTENDANT WHEN YOUR TRAVEL USING TRANSIT? _____ YES _____ NO

11. PLEASE ANSWER THE FOLLOWING QUESTIONS.

CAN YOU TRAVEL 200 FEET WITHOUT ASSISTANCE? ____ YES ____ NO

CAN YOU TRAVEL 500 FEET WITHOUT ASSISTANCE? ____YES ____ NO

CAN YOU TRAVEL 700 FEET WITHOUT ASSISTANCE? ____ YES ____ NO

CAN YOU TRAVEL ¼ MILE WITHOUT ASSISTANCE? ____ YES ____ NO

CAN YOU TRAVEL ¾ MILE WITHOUT ASSISTANCE? ____ YES ____ NO

CAN YOU CLIMB THREE 12 INCH STEPS WITHOUT ASSISTANCE? ____ YES ____ NO

12. I HERE CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT.

_____

SIGNATURE DATE

13. IF THIS APPLICATION HAS BEEN COMPLETED BY SOMEONE OTHER THAN THE PERSON REQUESTING CERTIFICATION PLEASE PROVIDE FOLLOWING INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

14. EMERGENCY CONTACT NAME:_____ PHONE _____

15. IN ORDER TO ALLOW LEBANON TRANSIT TO EVALUATE YOUR REQUEST IT IS NECESSARY TO CONTACT A PHYSICIAN OR OTHER PROFESSIONAL TO CONFIRM THE INFORMATION YOU HAVE PROVIDED: PLEASE COMPLETE THE ATTACHED MEDICAL RELEASE WITH PROPER INFORMATION.

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MEDICAL RELEASE FORM

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone: _____

I hereby authorize the Health Care Professional to release to the Lebanon Transit (LT) information about my disability.

_____

Signature Date

Health Care Professional info:

Name of Health Care Professional: _____

Phone: _____

Address: _____

City, State, Zip: _____

200 Willow St. Lebanon, PA 17046

Phone: (717)274-3664 Fax: (717)274-8860 Website: www.lebanontransit.org