



lebanon transit

ADA SHARED RIDE APPLICATION

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

IS THE CONDITION TEMPORARY? ____ YES ____ NO
IF YES, EXPECTED DISABILITY UNTIL: _____

8. HOW DOES THIS DISABILITY PREVENT YOU FROM USING OUR FIXED ROUTE SERVICES? PLEASE EXPLAIN COMPLETELY, USE ADDITIONAL PAPER IF NECESSARY.
9. ARE THERE ANY OTHER EFFECTS OF YOUR DISABILITY WHICH WE SHOULD BE MADE AWARE OF?

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

<input type="checkbox"/> CANE	<input type="checkbox"/> CRUTCHES	<input type="checkbox"/> GUIDE DOG
<input type="checkbox"/> MANUAL WHEELCHAIR	<input type="checkbox"/> ELECTRIC WHEELCHAIR	

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

12. 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

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

SIGNATURE DATE

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

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____

15. EMERGENCY CONTACT NAME: _____ PHONE _____

16. 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

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