Application for Paratransit Service

Please complete this application as thoroughly as possible and to the best of your ability. If there are questions that you cannot answer, or if you need assistance to complete this form, please call Transportation Paratransit at (706) 369-5991. To be considered complete, every question on the application must be answered. If not, then the application will be returned to you for completion.

You will have seven business days to return the completed Application for Paratransit Service to the Paratransit Office in order to continue to use the service. You may continue to use the service during that seven business days.

* Students requiring use of the Paratransit Service as an ADA accommodation should contact the Disability Resource Center at 706-542-8719 for further information.

* Faculty/Staff requiring use of the Paratransit Service as an ADA accommodation should contact Adrianna Creech of Faculty and Staff Relations, Human Resources at 706-542-9756 for further information.
PART I: APPLICANT INFORMATION
PLEASE TYPE OR PRINT IN BLUE OR BLACK INK
REQUEST FOR PARATRANSIT SERVICE

☐ New Applicant  ☐ Recertification - ID# _________________________

☐ Faculty        ☐ Staff            ☐ Student          ☐ Guest

Name: ____________________________________________________________

First                                                M.I.                                           Last

Permanent Address: ______________________________________________________

____________________________

Local Address: ______________________________________________________

____________________________

Phone number ______________________________

Date of Birth ______________________________

Emergency Contact Person: _____________________________________________

Phone Number: ______________________________________________________

Relationship to Applicant: _____________________________________________
PART II. HEALTH CONDITION INFORMATION

1. What limitations prevent you from using our fixed route service, Transportation and Parking Services Transit buses? Please explain completely. Use an additional sheet if necessary.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
_________________________________________________________

a. Is this condition temporary?

b. If yes, what is the expected duration? Please indicate the number of ________
days/weeks/months (please circle one) or provide the anticipated date when
applicant will no longer need to use Paratransit Services: _____/_____/____

c. Date of diagnosis: ___________________________

2. Please note any other aspects of your condition that Paratransit Services may need to know in order to ensure that an appropriate vehicle is assigned to transport you, and to make an accurate analysis of your travel.

______________________________________________________________________________
______________________________________________________________________________
_________________________________________________________

3. Do you use any of the following mobility aids? ☐ No ☐ Yes—check all that apply.

☐ Manual Wheelchair ☐ Powered Scooter ☐ Crutches ☐ Knee Scooter

☐ Motorized Wheelchair ☐ Cane ☐ Guide Dog ☐ Brace (s)

☐ Walker

4. Do you require a Personal Care Attendant when you travel? ☐ Yes ☐ No

5. Please provide a brief description of yourself to enable the drivers to identify you:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
_________________________________________________________

6. Please answer the following questions:
a. Can you travel 200 feet without assistance?
   □ Yes □ No □ Sometimes
   
   Please provide any additional relevant information:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

b. Can you travel ¼ mile without assistance?
   □ Yes □ No □ Sometimes
   
   Please provide any additional relevant information:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

c. Can you climb three 12-inch steps without assistance?
   □ Yes □ No □ Sometimes
   
   Please provide any additional relevant information:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

d. Can you wait outside without support for ten minutes?
   □ Yes □ No □ Sometimes
   
   Please provide any additional relevant information:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Applicant Signature:__________________________________________
Printed Name:________________________________________________ Date: ____________
I certify that the information in this application is true and correct to the best of my knowledge and ability. I also certify that the above information provided by my patient is true and correct to the best of my knowledge and ability.

Signature __________________________________ Date: __________

Printed Name________________________________________ Title (e.g.,) MD, NP, PA __________

Business Address:_____________________________________

Business Phone: Number:______________________________