UNIVERSITY OF GEORGIA
Transportation & Parking Services

*****CONFIDENTIAL INFORMATION*****

Application for Paratransit Service

Name: _____
First **M.I.** **Last**

Date of Application: _____

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 completing this form, please contact Paratransit at (706) 369-5991. Every question on the application must be answered to process your application as complete. Leaving answers blank will cause the application to be returned and delay the starting date of service. Please email the Application to: vans@uga.edu

* Students requiring use of the Paratransit Service as ADA accommodation should contact the Accessibility and Testing at 706-542-8719 for further information.

* Faculty/Staff requiring use of the Paratransit Service as ADA accommodation should contact 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:

_____

_____

Residential Hall: _____

Address: _____

_____

Phone Number _____ **UGA MyID Email Address** _____

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 added 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 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 ☐ Service Animal ☐ Brace (s)

☐ Walker

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

_____

5. 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:** _____

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PART III: Certification from a Licensed or Certified Health Care Provider

This section must be completed by the licensed or certified health care provider who can verify the student's condition and mobility needs. Students with temporary injuries (e.g., broken bones, recovery from surgery) may be eligible for temporary accommodation through Paratransit. To provide appropriate temporary accommodation for this student, please complete all appropriate sections of this form as comprehensive documentation assists the Transit Office in determining appropriate accommodation. If you have any questions, please contact us at (706) 369-5991.

Student Name: _____ **D.O.B.** _____

Current Diagnosis(es): _____

Diagnostic Criteria or Evaluation Method: _____

Expected duration for temporary services (not total recovery time): _____

Medical Provider Information

Name: _____ **Specialty:** _____

Title: _____ **Phone:** _____

Office Address: _____

_____

License/Certification # and State of License: _____

Date of Last Service Provided to Student: _____

Signature: _____ **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.