



PARA TRANSIT APPLICATION FORM

COMPLETE FORM AND RETURN VIA EMAIL, FAX OR IN PERSON

Email: mlocke@brockville.com

Fax: 613-342-5035

In Person: Brockville City Hall (1 King Street West)

Gord Watts Municipal Centre (251 North Augusta Road)

ELIGIBILITY CRITERIA

Only Applicants that are physically or cognitively unable to use Conventional Transit are eligible for use of Para Transit.

All Brockville Conventional and Para Transit buses are accessible and outfitted with mobility lifts.

PART A - APPLICANT INFORMATION

Applicant Name: _____

Address: _____

Postal Code: _____

Telephone: _____ E-mail: _____

Emergency Contact
Name: _____

Emergency Contact
Telephone: _____

Applicant Signature: _____

Date Submitted: _____

PART B – HEALTHCARE PROFESSIONAL CERTIFICATION

Section to be completed by Applicant’s attending physician or other healthcare professional with knowledge of their condition. Forms not signed by a healthcare professional will not be accepted.

1. Is the Applicant physically able to climb and/or descend stairs?
 Yes No
2. Is the Applicants physically able to walk a distance of 175 metres?
 Yes No
3. Does the Applicant have the ability to use Conventional Transit alone?
 Yes No
4. Does the Applicant have the ability to use Para Transit alone?
 Yes No
5. Does the Applicant require a Support Person to accompany them on the Para Transit vehicle? A Support Person is an individual required to assist the Applicant for mobility or cognitive reasons as the Applicant cannot ride on the vehicle alone without assistance. Social Companions are also eligible to travel with approved riders not requiring a Support Person if space is available. Social Companions are required to a pay a fare.
 Yes No
6. Describe the Applicant’s condition as it pertains to mobility or cognitive function in using Transit services

7. Does the Applicant use mobility aids?
 Yes No

If yes, please identify:

8. For what time period will the Applicant require Para Transit Services?

Permanent

Conditional

Temporary

Start: _____ End: _____

PART B – HEALTHCARE PROFESSIONAL CERTIFICATION

Section to be completed by Applicant’s attending physician or other medical professional with knowledge of their condition. Forms not signed by a healthcare professional will not be accepted.

I hereby certify that the applicant meets the Para Transit eligibility criteria by answering “no” to question #1 or #2 or #3.

(Please print clearly and complete every section)

Name: _____

Professional Designation: _____

Address: _____

Telephone Number: _____

Signature: _____