

# ACCESSIBLE SERVICE APPLICATION

PLEASE PRINT CLEARLY

Revised: August 2020

Ensure ALL fields are completed for accurate and timely processing

Form must be signed by the applicant and their attending physician or authorized nurse practitioner

SELECT COMMUNITY:  CHATHAM  WALLACEBURG

**NOTE:** The Accessible Bus Service is a non-profit transportation system for people challenged with physical or intellectual disabilities and are unable to move about freely with dignity within our community. Alternatively, for citizens that would not be able to use the Conventional public transportation.

FACILITY: \_\_\_\_\_ Current Date: \_\_\_\_\_  
month / day / year

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name First Name month / day / year

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Street # and Name Room/Apt. # City/Prov. Postal Code

Type of Disability: \_\_\_\_\_

Is Accessible Service required  Permanently  Temporarily

Mobility Device Used?  Wheelchair  Crutches  Cane  Walker  Other \_\_\_\_\_  
specify

Is an attendant required to assist you with mobility?  Yes  No

Purpose of trip:  Shopping  Educational  Employment  Medical  Recreational

Other \_\_\_\_\_  
specify

No. of TRIPS per week: \_\_\_\_\_

Doctor's Remarks:

Would you like blank Accessible Smart Card for Online Loading mailed w/ the approval letter? Yes No

I, Dr. \_\_\_\_\_ (attending physician's name) hereby certify that \_\_\_\_\_ (patient's name) is unable to use the public CONVENTIONAL transit system.

Applicant's / Caregiver's Signature

Doctor's Signature

PLEASE RETURN FORM TO:

Municipality of Chatham-Kent  
Engineering & Transportation Division  
315 King Street West, P.O. Box 640  
Chatham, ON N7M 5K8  
Tel. No.: 519-360-1998 / Fax No. 519-436-3240  
Email: [cktransit@chatham-kent.ca](mailto:cktransit@chatham-kent.ca)  
Website: [www.cktransit.ca](http://www.cktransit.ca)

Doctor's Name (print): \_\_\_\_\_

Doctor's Tel. No.: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_