ACCESSIBLE SERVICE APPLICATION

PLEASE PRINT CLEARLY *Revised: January 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 _____ **No. of TRIPS per week:**_____
specify

Doctor's Remarks: _____

_____

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
Website: www.cktransit.ca

Doctor's Name *(print)*:_____

Doctor's Tel. No.:_____

Doctor's Address:_____

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