TCTS APPLICATION FORM

Name: ______________________________________Date of Birth________________________
Civic Address: ____
Mailing Address: ____
Postal Code: _____________________ Telephone: ( ) _______________________________

Do you have a medical condition, physical or mental disability? ___Yes ___No

If yes, please advise on how we can assist you while you're using our service:

____
____
____

Do you require a wheelchair for mobility? ___Yes ___No

Do you require a wheelchair accessible vehicle? ___Yes ___No

If so, is your home equipped with a wheelchair ramp? ___Yes ___No

Do you require assistance getting in and out of your home or our vehicle? ___Yes ___ No

Do you require an attendant? ___ Yes ___No

Do you receive financial assistance to help pay the cost of your drive? ___Yes ___No

If so, who are you covered by?

___Department Community Services ___Department of Veterans Affairs
___Workers Compensation Board ___ NIHB, First Nations and Inuit Health Branch

Do you have pets which may be a concern to our drivers when picking you up? ___Yes ___No

What will be your main purpose for using our service?

_____Social or recreational ____Employment ____Medical,
_____Household errands ____Family ____Other

How did you hear about our service? ____

In case of emergency, we need to contact: ______________________________________

Relation:____Telephone:________________

I, _________________________, agree to abide by the rules and regulations set forth by the Trans County Transportation Society.

____________________ ______________________________________

Date **Member's signature**

Trans County Transportation Society
PO Box 193, Bridgetown, NS
B0S 1C0
(902) 665-1212

MEMBER WAIVER

I, ________________________________,
(PLEASE PRINT)
Recognize that the mission of Trans County Transportation Society is to assist me in overcoming barriers to transportation. I acknowledge that the drivers have been screened *only* as operators of motor vehicles and are not required to have training in medical support. I acknowledge that any assistance from a driver comes from one concerned individual to another and that Trans County Transportation Society drivers are not medical attendants. I am responsible for obtaining my own medical attendant.

TCTS member/:_______________________________(Signature)
Or Legal guardian

Witness:____(Signature

Date:_____________________