Mobility Transit Application

City of Owen Sound
Mobility Transit
808 2nd Avenue East
Owen Sound, ON
N4K 2H4
Phone: 519-376-4440 ext. 1251
mobilitytransit@owensound.ca

Both Part A and Part B must be completed in order for your application to be processed.

Please return the completed form to the address listed above.

The Mobility Transit service is intended for those persons who, due to a functional impairment, limitation, or restriction cannot board, ride or disembark from City of Owen Sound's Conventional Fixed- Route System.

Owen Sound's Conventional Fixed-Route Transit buses are all Accessibility for Ontarians with Disabilities Act (AODA) compliant. Every bus has a wheelchair ramp and tie-down locations to accommodate two wheelchairs or powered wheelchairs. Due to space restrictions, mobility scooters are not permitted on Conventional transit buses.

- The information provided on this application is of a confidential manner, and is for the sole use of consideration of service on the Specialized Transit System in the City of Owen Sound. It is protected from access by the Freedom of Information and Protection of Privacy Act, 1990.
- This application is subject to review by the Operations Department – Transit Division and any other persons deemed appropriate at any time.
- Applications will be effective for up to 3 years.
- If you have any questions or need assistance, please call Owen Sound Mobility Transit staff at 519-376-4440 ext. 1251

TO APPLY FOR SPECIALIZED TRANSIT SERVICE:

1. Complete Part A of this application in full.
2. Have a Health Care Professional or approved Disability Services Executive Director complete Part B.
3. Return the completed application (Parts A and B) to Owen Sound Transit in a sealed envelope (address above) or by email to mobilitytransit@owensound.ca .

   City staff will notify you of your application being processed and your access to booking.
   If you have not been notified within 14 days of submitting your application, please contact us.

   All information collected on this application form will be kept confidential.

Failure to complete both Part A and Part B in full will result in delay.

Part A – Applicant information

First name: **Middle initial:** **Last name:**

Home address:

Phone #: **Alt. Phone #:**

E-mail address: **TTY/TDD#:**

Date of Birth:

Do you require a support person when you travel?

☐ **Yes** ☐ **No**

Emergency Contact information

First name: **Middle initial:** **Last name:**

Telephone: **E-mail address:**

Relationship:

I hereby certify that to the best of my knowledge, the information provided above is true and accurate and I authorize the authorized Health Care or Disability Service professional named in part B of this application to provide information to the Public Works & Engineering department, Transit division at the City of Owen Sound.

_____ _____

Signature Date: MM/DD/YYYY

If you are NOT the applicant but have completed this application on the applicant's behalf, please sign below to certify that, to the best of your knowledge, the information provided in this application is true and accurate.

_____ _____

Signature Date: MM/DD/YYYY

_____ _____

Designee Name (please print) Date: MM/DD/YYYY

Part B – Health Care Professional Authorization

Part B must be filled out by one of the authorized health care practitioners*. Specialized Transit service is intended for those persons who, due to a functional limitation, cannot board, ride or disembark from the City of Owen Sound's Accessible Conventional Fixed- Route System.

IMPORTANT: This section *only* needs to be completed for **New** applicants. **Renewal/Expired** and **Lost card** applicants do *not* need to have it completed.

***Type of Accepted Health Care Professional (select one)**:

☐	Physician	☐	Speech Language Pathologist
☐	Nurse	☐	Occupational Therapist
☐	Social Worker (RSW)	☐	Audiologist
☐	Physiotherapist	☐	Psychiatrist
☐	Behaviour Analyst (BCBA)	☐	Recreational Therapist
☐	Psychologist	☐	Optometrist
☐	Executive Director of a Disability Services Provider		
	*Organization Name: _____		

Professional Stamp (if available)

How long will the Mobility Transit service be required?

- ☐ Permanently
- ☐ Temporarily – Expected duration _____ to _____
- ☐ Seasonal/Conditional (limitation impacted by seasonal ice, snow or heat conditions)
  Service required: ☐ May to September ☐ October to April

Client's/Patient's name : _____

Name of Health Care Professional OR Executive Director: _____

Professional Registration Number: _____

Practice/Service Address:_____ **Unit #**: _____

City:_____ **Province**:_____ **Postal Code**: _____

Phone: (_____) -_____-_____x._____ **E-mail**: _____

By signing below, I further certify that the information I have provided in this application is accurate and complete to the best of my knowledge.

Health Care Professional OR Executive Director Signature:

_____ **Date**: _____

-Signatures from other types of health care professionals not included on the list above will **NOT** be accepted;
-**NO OTHER** forms or letters will be accepted in place of this section – e.g. diagnosis letters;
-The City of Owen Sound is committed to protecting the privacy, confidentiality and security of any personal information we collect, use, and retain.