**WHEELING TOWNSHIP – TRANSPORTATION**
1616 N. Arlington Heights Road Arlington Heights Illinois 60004
T: 847.259.7743 F: 847.259.1570 www.wheelingtownship.com

## REGISTRATION FOR BUS – *PERMANENT DISABILITY* – AGE 18 AND OVER

(Please print clearly)

**Name** _____ **Birth Date** _____

**Street Address** _____

**City**_____**Zip Code** _____

**Phone**_____ **Cell Phone** _____

**Email**_____

**Emergency Contact**_____ **Relationship**_____

**Phone 1**_____ **Phone 2** _____

*Please check all categories that apply:*

**_____ Mobility Limited _____Hearing Impaired _____ Respiratory _____Cardiac**
**_____ Visually Impaired _____ Speech Impaired ____ Neurological _____Renal/Dialysis**
***Aids Used (if any):*** **_____Wheelchair _____ Walker _____Braces _____Prosthetic Device _____**
**Attendant _____ Crutches or Cane _____Service Animal __Other_**

**Do You Need the Lift Equipped Bus? _____Yes _____No**

*Please answer the following:*

**Have you been diagnosed with a communicable disease? _____Yes _____ No**
**Persons with communicable disease may not ride on the township transportation system. You may be required to provide a physician's statement certifying that you are free of a communicable disease.**

**Do you require a lift-equipped bus? ____Yes ____ No**

**Will you have a caregiver riding with you? _____Yes ____ No**

**Are you able to keep balanced while seated on a moving vehicle? _____ Yes _____ No**

**Can you climb 12-inch steps without assistance? _____Yes _____ No**

***If you use a wheelchair or a scooter:***
**Are you able to independently maneuver on and off a wheelchair lift? _____ Yes _____ No**

**Are you and a caregiver able to maneuver you and your mobility device, if any, on and off the bus? _____ Yes _____ No**

**Is the total weight of you and your mobility device 600 pounds or more? _____ Yes _____ No**

**What are the overall dimensions of the mobility device, including head and foot extensions (inches)?**
**Length_____in. Width_____in. Height _____in.**

***If a wheelchair or a scooter is used, appropriate ramps must be installed at the passenger's home before bus service will be started. The Township Senior & Disability/Transportation Department, with the assistance of the drivers, will make initial and subsequent evaluations regarding the ability to safely transport all registrants.***

*Please Complete Reverse Side (Over)*

**Last Name** | ***(Office Use Only)*** | **First Initial**

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**Passenger Waiver and Release (required)**

**To the extent allowed by law, I, _____("Passenger"), waive and release Wheeling Township, its Board members, employees, volunteers and agents from any and all causes of action, suits, damages and expenses, which I now have or may acquire, by reason of injury or other damage which may incur as a passenger of Wheeling Township's Senior Disabled Transportation services.**

_____ _____
**Registrant's name (print clearly)** **Signature**

_____
**Date**

***Note:*** **We must have ORIGINAL signatures, not photo or facsimile copies.**

**You must provide proof of age and residency.**
**Proof of age: Copy of a Driver's License or State I.D. (showing date of birth) or a birth certificate**
**Proof of residency: Copy of a Driver's License, State I.D., utility bill, rent receipt, property tax bill**

**WHEELING TOWNSHIP RESERVES THE RIGHT TO MAKE FINAL DETERMINATION OF RIDER ELIGIBILITY.**

***PLEASE SEE THE FOLLOWING PAGE FOR YOUR PHYSICIAN TO COMPLETE AND RETURN TO WHEELING TOWNSHIP.***

**----------**

**FOR TOWNSHIP OFFICE USE ONLY**: DATE _____
APPLICATION: APPROVED _____ DENIED _____ REASON FOR DENIAL_____

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**Date_____**

**Patient Name _____ Birth Date _____**

**Street Address _____**

**City_____ Zip Code _____**

***PHYSICIAN STATEMENT - (MUST BE COMPLETED BY PHYSICIAN)*** **(PLEASE PRINT)**

**NOTE THAT WHEELING TOWNSHIP DISABILITY TRANSPORTATION SERVICE IS FOR PERSONS AGE 18 AND OVER WITH PERMANENT DISABILITIES.**

***A PERSON WITH A DISABILITY:***

**. Has a physical or mental impairment which substantially limits one or more major life activities;**
**. Has a record of such impairment; or**
**. Is regarded as having such impairment, whether he/she has the impairment or not.**

**"Major life activities" includes caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, sitting, standing, lifting and working; as well as mental and emotional processes such as thinking, concentrating, and interacting with others.**

**1. Is this a PERMANENT disability? Y/N _____**

**2. In your opinion, is the patient able to ride the Wheeling Township Bus? Y/N _____**

**3. In your opinion, does this person require a caregiver or assistant to safely navigate the bus? (For the additional safety of our passengers, we prefer that all riders with disabilities be accompanied by a caregiver/ assistant / family member. ) Y/N _____**

**4. Type of disability (PLEASE DESCRIBE & BE SPECIFIC): _____**
_____

**5. Is the patient ambulatory? Yes _____ No _____**
**Describe the patient's level of mobility: _____**
_____

**6. Other comments, especially regarding safety? _____**

**PHYSICIAN'S NAME (Please print): _____**

**PHONE # (_____) _____**

**BUSINESS ADDRESS: _____**
**CITY _____ ZIP_____**

**PHYSICIAN'S SIGNATURE: _____ LICENSE #**
_____

**Note: It may be necessary to resubmit documentation for conditions not of a chronic nature.**