WHEELING TOWNSHIP - DISABILITY BUS SERVICE

Rev. 9-30-08

1616 N. ARLINGTON HEIGHTS ROAD, ARLINGTON HEIGHTS ILLINOIS 60004

BUS SERVICE: 847-259-7743 GENERAL OFFICE: 847-259-7730

REGISTRATION due to PERMANENT DISABILITY - AGE 18 AND OVER

Please print clearly.

NAME ____ **BIRTH DATE** _______________

STREET ADDRESS____

CITY ____________________________**ZIP** _______ **HOME PHONE (**_____**)** ____________

EMERGENCY CONTACT **(NAME)** ____________________________________ **RELATIONSHIP:** ____________

EMERGENCY CONTACT PHONE NUMBER (_____**)** ______ _______________________

PLEASE INDICATE ANY AIDS USED (PLEASE CHECK ALL WHICH APPLY):

____ Wheelchair/ Scooter/ Power Chair _____ Brace ___ Walker ____ Crutches/ Cane
____Oxygen ___ Service Dog Other: Explain: ___________________________________

1. **All riders with disabilities must complete an in-office interview at Wheeling Township. The purpose is to review necessary safety procedures and inspect any equipment and aids used by the applicant. It is helpful if any caregivers also attend this interview to participate in the discussion. The Township will provide transportation for this interview.**
2. **If a wheelchair or scooter is used, appropriate ramps must be installed at the passenger's home before bus service will be provided.**

Please answer the following:	YES	NO
1. Is your condition temporary?	____	____
2. Do you require a lift-equipped bus?	____	____
3. Will you have a caregiver riding with you?	____	____
4. Are you able to keep balanced while seated on a moving vehicle?	____	____
5. Can you climb three 12-inch steps without assistance?	____	____
6. If you use a wheelchair or scooter:		
. Are you able to independently maneuver on and off a wheelchair lift?	____	____
. Are you and a caregiver able to maneuver you and your mobility device on and off the bus?	____	____
. Is the TOTAL weight of you and your mobility device more than 600 lbs?	____	____

. What are the overall dimensions of the chair, including head and foot extensions (inches)? _________ **Length** _________ **Width** __________ **Height**

Section II: 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 I may incur as a passenger of Wheeling Township's Disability Transportation Service.**

________________________ ________________________ ________

Print clearly registrant's name **Signature** **Date**

(must be original signature, not a copy or fax)

You must provide proof of age and residency!

. For proof of age: send a copy of Driver's License or State I.D. (showing date of birth) or birth certificate.

. For proof of residency: a state issued I.D., utility bill or rent receipt

When your COMPLETED registration form is received, you are eligible to call and make your reservations. No further notification will be made or pass issued.
Wheeling Township reserves the right to make final determination of eligibility.

Section III: PHYSICIAN STATEMENT (MUST BE COMPLETED BY PHYSICIAN)

(PLEASE PRINT OR TYPE CLEARLY)

NOTE THAT WHEELING TOWNSHIP DISABILITY BUS SERVICE IS FOR THE USE OF PERSONS 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.

FOR WHEELING TOWNSHIP OFFICE USE ONLY: DATE _____________
APPLICATION: APPROVED ______ DENIED ________ REASON FOR DENIAL_______________________
PROOF OF AGE & RESIDENCY SUBMITTED: Driver's License ______ Other______________________