Mobility Bus Application Form

Please complete all applicable sections.

A Health Care Professional must complete the **Professional Certification section** before your application can be processed.

Applicant Information

I confirm that I am a City of Belleville resident (Ward 1 or 2) ☐ Yes

First name: _____

Last Name: _____

House/911 number: _____ Street name: _____

Apt. or unit #: _____ City: _____ Postal Code: _____

Primary Phone Number: _____

Secondary Phone Number: _____

Birthdate: _____

E-Mail Address: _____

Emergency Contact

Name: _____

Phone Number: _____

Relationship: _____

Mobility Requirements

Do you use: (check all that apply)

☐ Wheelchair
☐ Walker
☐ Scooter
☐ Cart
☐ Crutches
☐ Cane
☐ Other: _____

I need to travel with an attendant: ☐ Yes ☐ No

Please check all that apply to you:

☐ Difficulty walking long distances

☐ Difficulty standing or balancing

☐ Use of wheelchair or power chair

☐ Use of walker, cane, scooter, or other mobility aid

☐ Other medical or mobility related condition: _____

APPLICANT DECLARATION

I hereby certify that to the best of my knowledge, the information given above is correct.

I authorize the release of medical information to the City of Belleville. I consent to the contents of my application and eligibility for specialized transit services discussed with the health care professional that completed part of this application.

Signature of Applicant or Designate: _____

Date: _____

Important

Your application cannot be processed until the Professional Certification section has been completed by an acceptable healthcare professional.

Acceptable health care professionals include:

- Licensed Physician
- Registered Occupational Therapist
- Licensed Physical Therapist
- Registered Nurse
- Certified Psychologist or Psychiatrist
- Licensed Optometrist, Ophthalmologist, or Eye Physician

Mobility Bus Application - Professional Certification

City of Belleville residents applying to use Mobility Transit must provide Professional Certification, which must be completed by a health care professional.

You are being asked by the applicant to provide information regarding his/her ability to use public transit and whether they need a support person to travel with them. The information you provide will allow us to evaluate the request and to provide the appropriate service.

Completing for Applicant

Based on your professional assessment, does this individual have a mobility or health-related condition that prevents them from safely using conventional transit services?

☐ Yes ☐ No

The limitation is:

☐ Permanent

☐ Temporary, expected duration: _____

Please indicate the challenges experienced by the applicant (check all that apply):

☐ Support person is required for travel
☐ Unable to walk long distances to or from bus stops
☐ Difficulty standing or balancing while waiting for transit
☐ Difficulty boarding or exiting conventional buses
☐ Requires mobility aid (wheelchair, walker, scooter, etc.)
☐ Vision-related barriers affecting independent travel
☐ Cognitive or medical condition affecting safe independent travel
☐ Other functional limitation: _____

Additional Comments (optional):

Healthcare Provider Name: _____

Clinic/Organization: _____

Phone Number: _____

Healthcare Professional Signature: _____ **Date:** _____

Please return the completed form to bellevilletransit@belleville.ca or Transit Services, 400 Coleman Street, Belleville, ON K8P 3J4.

Personal information on this form is collected under the authority of the Municipal Freedom of Information and Privacy Protection Act and will be used to assess the individual's qualifications for the Mobility Bus Service and will remain Confidential.