SAULT STE. MARIE

**Sault Ste. Marie Parabus Application**

**111 Huron Street, Sault Ste. Marie, Ontario, P6A 5P9**

**Tel: (705) 942-1404 Fax: (705) 759-5834**

**Section "A"** To be completed by the Applicant, Family, or Legal Guardian

Name of Applicant:

Address: Apartment #: Postal Code:

Date of Birth (mm/dd/yy):

Mobile Phone: Home Phone:

Email Address:

Preferred Method of Communication: Phone ☐ Email ☐ Letter ☐

Preferred Method of Communication in the event of a Service Delay of over 30 minutes:

Phone ☐ Text ☐

**Direction for release of medical information:**

I hereby authorize you (the physician or designated professional) to release any medical information which may be required by an official of Transit Services to aid in determining my eligibility for Parabus service in the community.

**Signature of applicant:**

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**Section "B"** To be completed by a Physician/Nurse Practitioner/Chiropractor/Occupational Therapist/Physiotherapist:

1) Describe how the applicant's disability prevents them from using conventional transit.

2) Does the applicant have vision loss that affects their ability to use conventional transit?

Applicant Name:

3) Are there any other conditions or factors that would prevent the applicant's safe use of conventional transit?

4) Applicant is applying for (Check one box):

Permanent ☐ Conditional or Temporary ☐

Please provide details for conditional or temporary approval above (i.e. seasonal, weather):

Conditional or temporary approval for how long (Check one box)?

3 Months ☐ 6 Months ☐ 12 Months ☐

**Please indicate YES or NO for each of the following questions:**

5) Is the applicant physically able to walk 175m (an average city block)? Yes ☐ No ☐

6) Will the applicant require an assistant while travelling on the Parabus? Yes ☐ No ☐

**If YES** to #6 above, see instructions in Parabus brochure for more information on obtaining a Parabus Client Transit Card which will allow an attendant to ride the bus for free.

7) Does the applicant use a mobility aid? (Please mark spaces that apply)

None ☐ Walker ☐ Cane ☐ Crutches ☐

Manual Wheelchair ☐ Power Wheelchair ☐ Scooter ☐

Other (Please specify):

Date (mm/dd/yy):

Physician's Name:

Physician's Signature:

**Please allow 5-7 business days for application processing.**

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**Office Space Only**

**Date Approved:** **Temporary:**