

SAUGEEN MOBILITY

and REGIONAL TRANSIT

Box 40 Walkerton, ON N0G 2V0

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saugeenmobility.ca

CLIENT REGISTRATION FORM

Please FULLY complete both sides, sign and return

CLIENT INFORMATION AND LOCATION - Required

Name _____

Residential Facility (if any) _____

Address _____

_____ Municipality _____

Town/Village _____ Postal Code _____

Telephone Number _____

BILLING INFORMATION - Please complete ONLY if different

Name _____

Address _____

Town/Village _____ Postal Code _____

Telephone Number _____

ADDITIONAL CONTACTS - 2 Required

Name _____

Telephone Number _____

Name _____

Telephone Number _____

OVER

local and personal since 1977

OVER

PLEASE DESCRIBE YOUR CHALLENGES - Required

MOBILITY AIDS, ETC

Please indicate what mobility aids you are using.
If you are using a wheelchair, please provide the dimensions. This will assist us in sending the correct vehicle.

Chair Length _____ inches Chair Width _____ inches Electric? Y / N
Cane? Y / N Walker? Y / N Scooter? Y / N Oxygen? Y / N

Other _____

MEDICAL CONDITIONS AND OTHER INFORMATION

Please indicate any medical conditions or other information you feel our staff should know about.

ATTENDANT

An attendant may travel with each client at no additional charge.
An attendant may be required. Please enquire.
An attendant (family member, personal support worker, care facility worker, etc.) must be present to assist clients as needed onto and off of the vehicle.

CONFIDENTIALITY

Please be assured that all information collected on this form will be kept strictly confidential and will not be released without your permission.

A Signature is required. This form needs to be re-filed whenever information changes.

Signature _____ Date _____
Client, POA or other Representative

FOR OFFICE USE ONLY

Customer Code _____ Municipality Code _____
Staff Signature _____ Date _____