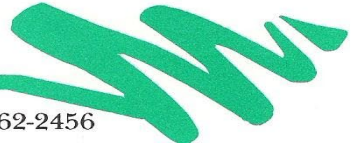


# Spruce Grove Specialized Transit Service

c/o 315 Jespersen Avenue, Spruce Grove, Alberta T7X 3E8 Phone 962-2456



## Application

**Instructions: All applicants must complete page 1 and 2. If you are have a disability and are under the age of 55, page 3 must be completed by a qualified health care or social services practitioner familiar with your case.**

Name: \_\_\_\_\_  
Surname First Name Middle Name

Name you go by: \_\_\_\_\_ Are you over 55 or under? \_\_\_\_\_ Over \_\_\_\_\_ Under

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell \_\_\_\_\_

Pick up Address: \_\_\_\_\_ Front Door: \_\_\_\_\_ Back Door: \_\_\_\_\_  
(if different from above)

Mailing address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
(if different from above)

Which primary mobility aid(s) do you use when traveling in the community: **(check all that apply)**

None	Long White Cane	Powered Wheelchair**
Walking Cane	Crutches	Collapsible Walker**
Leg Braces	Interpreter/Intervener	Manual Wheelchair**
Service Animal	Hearing Aid	Scooter**
Personal Attendant	Oxygen Tank	Walker**
Communication Devices	Prosthesis	Other

\*\* Please provide outside dimensions: \_\_\_\_\_

**Emergency Contacts:** List two people we can contact in case of an emergency.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell: \_\_\_\_\_ Cell: \_\_\_\_\_

Please provide any additional information that may be relevant to this application:

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**I hereby declare that the information provided above is true and correctly represents my condition. By signing this application I hereby give consent for STS to contact my emergency contacts and disclose my situation in an emergency.**

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_, 20\_\_\_\_\_  
**Date**

**PLEASE NOTE:** This application will be reviewed by the STS Screening Committee as soon as possible and you will be notified of their decision.

All locations served by the Specialized Transit Service (STS) must be accessible. Please confirm your destination is accessible BEFORE booking a trip. All locations must be kept free of snow and ice or we will not be able to provide service. All Wheelchair ramps must meet safety regulations or STS will not be able to provide service.

Please ensure all mobility aids are in good repair. STS must be able to secure your mobility aid or we may not be able to provide you with service. STS operators reserve the right to refuse clients service if they feel that mobility aides do not meet with appropriate safety size and weight restrictions.

STS operators will provide assistance to and from the **first set of accessible doors** and with the securing of mobility aids and seatbelts. STS operators are not responsible to assist with parcels, groceries etc.

If a mandatory attendant is required, the registrant will not be able to book any trips for travel without a mandatory attendant\*. This applies to all trips.

Passengers displaying unacceptable behavior that affects other passengers (and/or the Operator) will be required to ride with an attendant at all times.

**\*Definition of Mandatory Attendant:** A mentally competent person of legal age (18 years+) who is responsible for the actions and assistance of an STS registered client that requires assistance due to a medical condition and/or behavioral concern while utilizing the services of Spruce Grove Specialized Transit Service (STS).

**Completed applications can be:** Dropped off at 301 Jespersen Avenue Spruce Grove **Or**  
Mail to: Specialized Transit Service c/o 315 Jespersen Avenue, Spruce Grove, AB, T7X 3E8  
**Or** Fax to: 780-962-9501

**For more information please call (780)962-2456.**

**This information is being collected under the authority of section 33 (c) the Freedom of Information and Protection of Privacy (FOIP) Act. It will be used to administer services provided by the City of Spruce Grove operating as Spruce Grove Specialized Transit Service. The personal information provided will be protected in accordance with Part 2 of the Act. If you have any questions regarding the collection, use and disclosure of personal information, please contact the FOIP Coordinator at 780-962-2611.**

**This section to be completed by a Health Care Practitioner  
if applicant has a disability and is under the age of 55**

STS is a non-profit door to door public transportation service for all seniors and for youth, adults and families **who are unable to use regular transportation because of a physical or mental disability.**

Eligibility requirements include persons with disabilities and persons over the age of 55.

**\*This form must be completed in full and signed by a qualified health care practitioner familiar with the Applicant's disability (i.e. medical doctor, registered nurse, registered psychiatric nurse, occupational therapist, physical therapist, or rehabilitation practitioner).**

**For more information please call (780)962-2456.**

**What is the nature of the applicant's functional impairment or disability and how does it specifically restrict their ability to use a regular vehicle?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The disability is:** \_\_\_\_\_ permanent \_\_\_\_\_ temporary. **If temporary, please specify length of time that service is required, i.e. weeks/months** \_\_\_\_\_  
\_\_\_\_\_

**STS drivers must concentrate on the safe operation of the vehicle and cannot provide supervision to those who require constant or frequent attention because of medical or behavioral reasons.**

**In Your opinion should the applicant travel with an attendant?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Can applicant be left alone at their destination?** Yes \_\_\_\_\_ No \_\_\_\_\_

**PLEASE NOTE: STS does not provide attendants. If "yes," the applicant must travel with an attendant at all times, and the trip will not be accommodated if the attendant is not present.**

NEEDS ASSESSMENT AUTHORIZATION – I have assessed this applicant and based on my professional knowledge and opinion, I, the undersigned, recommend this individual as eligible to use the services of STS.

\_\_\_\_\_  
**Print name of Health Care Practitioner and title**

\_\_\_\_\_  
**Phone # and Ext.**

\_\_\_\_\_  
**Agency Affiliation (if any)**

\_\_\_\_\_  
**Practitioner's Address**

\_\_\_\_\_  
**Signature of Practitioner**

Health Care Professional Stamp (if applicable)

\_\_\_\_\_, 20\_\_\_\_\_  
**Date**