Stratford Parallel Transit Application
HEALTHCARE FORM

This form is to be completed by a Healthcare Professional to support the evaluation and eligibility process for the applicant applying for Stratford Parallel Transit.

APPLICANT ELIGIBILITY CRITERIA

I have been requested by (applicant name) _____
to provide accurate and current information regarding their need to use Stratford Parallel Transit.

☐ is physically unable to access our regular Stratford Transit bus.
☐ is physically unable to walk a distance of 175 metres (575 feet).

Please provide the applicant's relevant medical/surgical or health condition to support eligibility:

_____

_____

Is it expected that the applicant's condition will improve?

☐ 1 to 3 months ☐ 4 to 8 months ☐ 9 to 12 months ☐ 18 months
☐ 2 years ☐ Not yet determined ☐ Not at all

Does the applicant need transportation for the winter months only? ☐ Yes ☐ No

HEALTHCARE PROFESSIONAL INFORMATION

Name (please print first and last): _____

Signature: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Date of Completion: _____

STRATFORD PARALLEL TRANSIT OFFICE USE ONLY

Date application received: _____

Date APPROVED: _____

Approved by: _____

Reassessment Required: ☐ Yes ☐ No

Period: _____

Date: _____

Date NOT APPROVED: _____

Rejected by: _____

Reason: _____

Date ineligible notice mailed: _____