City of Cold Lake

COLD LAKE ADAPTIVE TRANSPORTATION SERVICE APPLICATION

Cold Lake Adaptive Transportation Service ("CLATS") is dedicated to providing a safe quality transportation service within the City of Cold Lake to persons with a permanent, temporary, or intermittent disability.

SECTION ONE: PERSONAL INFORMATION	
Full Name:	
Birth Date: (YYYY/MM/DD)	Gender:
Service Address:	
Mailing Address: *(if different)*	
Phone Numbers: (Home) (Work) (Cell)	
SECTION TWO: EMERGENCY CONTACT INFORMATION	
Contact Name:	
Relationship to Applicant:	
Phone Numbers: (Home) (Work) (Cell)	
SECTION THREE: MEDICAL DESIGNATION	

Please provide us with any relevant information that would assist the operator in providing you with safe transportation:

The following applies to this Applicant's permanent, temporary, or intermittent disability:

(check any that apply):

☐ Seizure Disorder
☐ Hearing Impairment
☐ Uses Alternate Form of Communication
☐ Amputee
☐ Visual Impairment
☐ Diabetes
☐ Cannot be Left Unattended
☐ Dementia
☐ Other (please explain): ____

____

The Applicant uses the following aids when performing daily tasks:

☐ None
☐ Walking Cane
☐ Leg Braces
☐ Service Animal
☐ Personal Attendant
☐ Prosthesis
☐ Long White Cane
☐ Crutches
☐ Interpreter/Intervener
☐ Hearing Aid
☐ Oxygen Tank
☐ Other, explain: ______________________________
☐ Wheelchair
☐ Walker
☐ Manual Wheelchair
☐ Scooter
☐ Communication Devices

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Is this application for temporary service? ☐ Yes ☐ No

If so, how long do you anticipate needing the service?
☐ 3 months ☐ 6 months ☐ 1 year ☐ Other: ___________________________

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

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SECTION FOUR: RELEASE OF LIABILITY, WAIVER, CLAIMS, AND INDEMNITY AGREEMENT

In consideration of travelling on the City of Cold Lake Adaptive Transportation Service, I hereby agree as follows:

To waive any and all claims that I have, or may have in the future, against The City of Cold Lake and Cold Lake and District FCSS, their staff, agents, and representatives (all of whom are hereinafter collectively referred to as “Staff”). **To release all Staff** from any and all liability for any losses, damage, injury, or expense that I may suffer, or that my next of kin may suffer, as a result of my participation in the activities due to any cause whatsoever. **To hold harmless and indemnify Staff** from any and all liability for any damage to property of, or personal injury to, any third party resulting from me travelling on the City of Cold Lake Adaptive Transportation Service. That this Agreement shall be effective and binding upon my heirs, next of kin, executors, administrators, and assigns in the event of death.

In signing below, I agree that I have been provided a copy the CLATS Handbook and understand the rules and regulations governing its operation.

SIGNATURE:_________________________________ DATE:_________________________

SECTION FIVE: ADDITIONAL PARTIES

If someone else has completed this form please indicate below.
(Advocate, guardian, or health/social service practitioner completing the form on behalf of the applicant).

Full Name:	Date:
SIGNATURE:	
Address:	Relationship to Applicant:

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SECTION SIX: PROFESSIONAL VERIFICATION

All Applicants are required to complete this section in order to be considered for service.

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

All applications provide sufficient information about the Applicant to allow staff to assess whether the Applicant is eligible for CLATS and under what conditions.

If the Applicant is applying for a seat belt exemption, Section Six MUST be signed only by a physician or surgeon. *Charges for completing this form or for obtaining additional information are the responsibility of the Applicant.*

Name of Practitioner or Provider:	
Professional Designation:	
Business Name:	
Business Address:	
Phone Number:	Fax Number:

MANDATORY ATTENDANT DESIGNATION

CLATS Operators must concentrate on the safe operation of their vehicle and the road conditions.

The Operators cannot supervise those who require constant or frequent attention due to medical or behavioural reasons.

IN MY OPINION should the Applicant travel with an attendant? ☐ YES ☐ NO ___________ *INITIAL*

If yes, please explain:

____

____

____

Can the Applicant be left alone at their destination? ☐ YES ☐ NO ___________ *INITIAL*

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SEATBELT EXEMPTION *(where applicable)*
Must be signed by Physician or Surgeon

Does the applicant's disability, health condition, or equipment restrict his/her ability to wear a seatbelt during transportation? If yes, this form **must** be completed and signed by a Physician or Surgeon.

IN MY OPINION should the Applicant be seat belt exempt? ☐ YES ☐ NO ___________ *INITIAL*

If yes, please explain:

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Pursuant to Alberta Regulation 122/2009, Highway Traffic Act*, Seat Belt Regulation Section 82 of the Act does not apply to a person if, in respect of that person, there is a certificate signed by a duly qualified medical practitioner certifying that the person:*

a) is, for the period stated in the certificate, unable for medical reasons to be secured in a child seating assembly or seat belt assembly, as the case may be, or

b) is because of size, build or other physical characteristics, unable to be secured in a child seat assembly or seat belt assembly, as the case may be.

I, ____, certify that I am a qualified health
PRINT NAME

care practitioner or RSW/BSW/MSW provider familiar with the Applicant's disability. I am of the opinion that the Applicant is in need of the Cold Lake Adaptive Transportation Service due to a condition or limitation that prohibits their ability to access an alternative means of transportation.

____ ________________________________

Practitioner or Provider Signature Date

Affix Stamp/Seal

INTERNAL OFFICE USE ONLY

Application Received: ______________________ Approved by: ______________________

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