Permit #:

(For Office Use Only)

PARALLEL TRANSIT SERVICE APPLICATION FORM

545 Talbot St., St. Thomas, ON N5P 3V7 Phone: (519) 631-1680 Fax: (519) 633-9019 Email: permits@stthomas.ca

The City of St. Thomas is authorized to operate a public transit service by cooperation of Section 11(3) of the Municipal Act, 2001. Personal information on the application form is collected under the authority of the Municipal Act, 2001, S.O. Chapter 25 and all personal information is protected and used in accordance with the provisions of the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA). The collection of personal information requested on the Parallel Transit Application Form is necessary to determine the applicant's current and on-going entitlement to the Parallel Transit service and for the proper administration of the Parallel Transit service. The City of St. Thomas uses the services of a third party contractor to schedule and provide Parallel Transit services. The third party ensures that all personal information is protected and used in accordance with the provisions of the MFIPPA. Please contact the Environmental Services Department at 545 Talbot Street, St. Thomas, ON, N5P 3V7, telephone (519) 631-1680 ext. 4161 for questions.

APPLICATION RESTRICTIONS

St. Thomas Transit provides door-to-door transportation for persons with a disability who are unable to use St. Thomas Transit conventional fixed-route bus service. Before you can use the Parallel Transit service, you must:

Part A: All applicants are required to fill out and sign Part A.

*****Choose between completing Part B or Part C***

Part B: Part B is entirely optional.

If you possess an Accessible Parking Permit issued by the Province of Ontario and would like to access Parallel Transit services without completing Part C, provide your permit number and expiry date.
Please bring your permit for verification when submitting the application.

Part C: If you opt not to fill out Part B, have your authorized regulated healthcare practitioner complete Part C.

PART A – APPLICANT INFORMATION

(to be completed by applicant or legal guardian)

Please indicate the reason for filling out this form:

☐ New Application ☐ Renewal of Permit ☐ Change of Information

First Name:		Last Name:			
Street Address:		City/Town:		Postal Code:	
Phone Number:	( )	Email Address*:			
Please let us know how you want the parallel transit service to get in touch with you:	☐	Telephone	☐	By Text (standard messaging rates may apply)	
Attendant Name (if required):		Attendant Phone Number:	( )		
Emergency Contact Name (if different than above):		Emergency Contact Number:	( )		

* Please give the email address you plan to use on the VOC app if you want to use parallel transit services on your mobile device.

DECLARATION: I authorize the release of health information for the completion of this form to the City of St. Thomas.

2024-04-10

Signature of Applicant or Legal Guardian — Date (YYYY/MM/DD)

ST. THOMAS
THE RAILWAY CITY

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PART B – ACCESSIBLE PARKING PERMIT INFORMATION (optional)

Accessible Parking Permit Number:	Expiry Date: _____ Date (YYYY/MM/DD)

PART C – HEALTH INFORMATION

(to be completed by Authorized Regulated Health Practitioner)

SECTION 1 – ASSESSMENT OF HEALTH CONDITION

please select all that apply

- ☐ Cannot walk without assistance of another person or a brace, cane, crutch, a lower limb prosthetic device or similar assistive device or who requires the assistance of a wheelchair.
- ☐ Suffers from lung disease to such an extent that forced expiratory volume in one second is less than one litre.
- ☐ Visual acuity is 20/200 or poorer in the better eye with or without corrective lenses or whose greatest diameter of the field of vision in both eyes is 20 degrees or less.
- ☐ Portable oxygen is a medical necessity.
- ☐ Cardiovascular disease impairment classified as Class III or Class IV to standards accepted by the American Heart Association or Class III or IV according to the Canadian Cardiovascular Standard.
- ☐ Condition(s) or functional impairment that severely limits his or her mobility.
- ☐ Severely limited in the ability to walk due to an arthritic, neurological, musculoskeletal, or orthopedic condition.

SECTION 2 – STATUS OF CONDITION

- ☐ **Permanent**
- ☐ **Temporary** – estimate length of the condition in number of months. _____
- ☐ **Conditional –** During severe weather conditions from November 15 to March 15 (winter with snow/ice).

SECTION 3 – REGULATED HEALTH PRACTITIONER INFORMATION

Regulated Health Practitioner Name:		Regulated Health Practitioner College #:	

I am registered with the following:

- ☐ College of Physicians and Surgeons of ON
- ☐ College of Nurses of ON
- ☐ College of Chiropractors of ON
- ☐ College of Occupation Therapists of ON
- ☐ College of Chiropodists of ON
- ☐ College of Physiotherapists of ON

Address of Health Practitioner

Street Address:		City/ Town:		Postal Code:	

Phone Number:	( )	Office Stamp with information (if available):	
Fax Number:	( )		

I certify that the applicant meets the necessary eligibility requirements as listed above.

Signature of Registered Health Practitioner Date (YYYY/MM/DD)

This form was last updated on April 9,2024