ST. THOMAS
THE RAILWAY CITY

Permit #:

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 Tracey Tiersma 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 must complete and sign Part A**

Part B **Is optional. If you have an Accessible Parking Permit issued by the Province of Ontario and wish to provide your permit number and expiry date, you will be eligible for Parallel Transit services without having to fill out Part C of this form. Bring your permit with you when you submit the applications, so that it may be viewed for verification purposes.**

Part C **If you have not completed Part B, have your authorized regulated health care practitioner complete Part C.**

PART A – APPLICANT INFORMATION – To be completed by applicant or legal guardian

☐ **New Parallel Transit Permit** ☐ **Renewal Permit**

☐ **Change of Information**

Last Name:		**First Name:**	
Full Address:		**Postal Code:**	
Phone Number:		**Birth Date:**	
Attendant Name (if required)		**Attendant Phone No.:**	
Emergency Contact Name:		**Emergency Contact Phone Number:**	

Declaration

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

_____ _____

Signature of Applicant or Legal Guardian **Date (mm/dd/yyyy)**

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PART B – ACCESSIBLE PARKING PERMIT INFORMATION (Optional)

Accessible Parking Permit Number:		**Expirty Date:**	_____ Date (mm/dd/yyyy)

PART C – HEALTH INFORMATION – To be completed by Authorized Regulated Health Practitioner

Section 1 – Assessment of Health Condition

- ☐ 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.
- ☐ 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.
- ☐ Severely limited in the ability to walk due to an arthritic, neurological, musculoskeletal or orthopaedic condition.
- ☐ 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.
- ☐ Condition(s) or functional impairment that severely limits his or her mobility.

Section 2 – Status of Condition

☐ Permanent

☐ Temporary → Estimated length of the condition in number of months. _____

Section 3 – Regulated Health Practitioner Information

Regulated Health Practitioner Name:		Health Practitioner Address:	
Regulated Health Practitioner College #		Phone Number:	
		Fax Number:	

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

_____ Signature of Registered Health Practitioner

_____ Date (mm/dd/yy)

I am registered with:

- ☐ College of Physicians and Surgeons of Ontario
- ☐ 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