ASSIGNED # _____

Riverview Access Transit Application Form

(revised August 2013)

Eligibility Criteria

To be eligible for the Access Transit service the applicant (citizen of Riverview or visitor) must permanently or temporarily require the use of a **wheelchair or scooter.**

- **Permanent Requirement** – is a person with a mobility impairment that is expected to continue indefinitely.
- **Temporary Requirement** – is a person with a mobility impairment that is expected to end.

Eligibility is determined by the Town of Riverview's Municipal Advisory Committee for Disabled Persons on the basis of: the application information provided, the physician's statement (see page 2) and a personal interview with a committee member.

If an applicant has been denied approval he/she may request a review and reconsideration of the application by the Town of Riverview Advisory Committee on Disabilities. The Advisory Committee is also available to provide information and advocacy support for ineligible applicants.

As the transportation of students (kindergarten to Grade 12) is the responsibility of the Province of New Brunswick there will be no subsidy paid for this age group.

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APPLICANT INFORMATION (Please Print)

Name: _____

Address: _____Postal Code: _____

Telephone: (home) _____ (work) _____ (email) _____

Social Development Social Worker (if applicable): _____

Emergency contact:

Name: _____Tel: _____

Escort Required: Yes__No__.
(only one escort per person is permitted free transit travel)

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Level of Access Transit Service Required (check one)

- o Permanent Requirement
- o Temporary Requirement

Reason(s) (employment, education, medical, other):
_____

Estimated Usage: ____ Trips Per Month

Applicant Signature: _____ Date:_____

RETURN completed form to: Town of Riverview, c/o Town of Riverview Advisory Committee on Disabilities, 30 Honour House Court, Riverview, New Brunswick, E1B 3Y9, telephone: 387-2210

Riverview Access Transit Physician Statement

Name of Physician:

_____

Address: **Postal Code:**

_____ _____

Telephone Number:

_____

I have examined _____ and certify that he/she will require the use of a **wheelchair or scooter** on a:

- **Permanent Basis ___** (physician's initials required)
- **Temporary Basis** ___ (physician's initials required). Recovery period _____days
- **Escort Required** Yes: ___ No: ___ (physician's initials required)

Attending Physician: _____Date: _____

Municipal Advisory Committee Use Only

Approved Permanent: _____ Date: _____

Approved Temporary:_____ Expires: Day ____ Month ____ Year _____

Not Approved: _____ Date: _____

Comments

Upon approval the applicant will be sent a letter of acceptance from the Town of Riverview.

Upon expiration of a temporary application, an applicant must complete a new Access Transit Application Form and Physician Statement if he/she wants to reapply for a transit services extension.

Town of Riverview Use Only

Completed Application Received: Day _____Month _____ Year _____
(the completed application will be reviewed and finalized within 30 days of date received)