

SECTION C: DISABILITY INFORMATION

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL:

(Physician, RN, Nurse Practitioner, Physiotherapist, Occupational Therapist, Chiropractor, MSW)

1. Are there conditions or special health care needs which would prevent the applicant's independent use of conventional transit? Please explain: _____

2. Status of Condition: Permanent Temporary: Estimated time in months _____
3. Does the applicant require the assistance of a Support Person (Personal Care Attendant) in order to travel on conventional public transit (HSR)?
 Yes No

CERTIFICATION BY HEALTH CARE PROFESSIONAL

Name of Health Care Professional (Please PRINT) _____

Professional Designation _____

Organization's Name _____

Address _____

Street Number and Name

Telephone

City

Province

Postal Code

Fax

I hereby certify that the information provided is accurate and complete to the best of my knowledge.

Signature of Health Care Professional

Date

Personal information on this form is collected under the authority of Section 227 of the Municipal Act, 2001, S.O. 2001, c.25 as amended, and is used solely to determine eligibility for the Support Person Identification Card for travel on Hamilton Street Railway buses. This information is held in strict confidence. Questions about this collection should be directed to:

**Accessible Transportation Services Attention:
Manager, Accessible Transportation Services
c/o 71 Main Street West
Hamilton, ON L8P 4Y5
(905) 529-1212**

****FOR OFFICE USE ONLY****

Date Approved _____

Comments: _____