



Mobility/Travel Training Program

MOBILITY TRAINING REQUEST FORM

SCOOTER/POWERCHAIR/MANUAL WHEELCHAIR

SECTION 1

To BE COMPLETED BY APPLICANT: PLEASE FILL OUT THE FOLLOWING SECTION.

DATE:			
NAME:			
ADDRESS:			
CITY/STATE/ZIP:			
TELEPHONE:	()	CELL	()

SECTION 2

To BE COMPLETED BY AGENCY/SCHOOL/CONSERVATOR: PLEASE FILL OUT THE FOLLOWING SECTION.

CONSERVATOR		AGENCY/SCHOOL	
NAME:		NAME:	
ADDRESS:		ADDRESS:	
CITY/STATE/ZIP:		CITY/STATE/ZIP:	
TELEPHONE:	()	TELEPHONE	()
CELL:	()	CELL	()
EMAIL:		EMAIL:	
ADA/CASE/SCHOOL ID#:		ADA/CASE/SCHOOL ID#:	

SECTION 3

To BE COMPLETED BY APPLICANT: PLEASE FILL OUT THE FOLLOWING SECTION.

1. Do you have a disability? Yes No Please state: _____

2. Are you currently taking medications? Yes No Please list and state for what conditions: _____

How many years have you been riding the bus? _____ Bus routes: _____

Route knowledge: GOOD FAIR NEEDS ASSISTANCE

Main objective: _____

Mobility device: Manual wheelchair Power chair Scooter Other

Type: Make/Model: _____

Dimensions: _____ Basket? _____

Preferred Transit Center/Station: _____ Preferred Day: _____

SECTION 4

To BE COMPLETED BY PCA/AIDE/TRAVEL BUDDY: PLEASE FILL OUT THE FOLLOWING SECTION.

4. Will you have a Travel Buddy/PCA/Aide with you on your training: Yes No

Name: _____ Signature: _____

Address: _____

City/State/Zip: _____

Phone: _____ Cell: _____

TRAINEES PLEASE NOTE: NCTD MUST BE NOTIFIED 48 HOURS IN ADVANCE OF ANY MOBILITY TRAINING CANCELLATIONS AT 760.966.6561. THANK YOU.

1. I understand that all personal information about me will be kept confidential. I understand that if I go on the day trip, I will be riding on public transportation and therefore release North County Transit District and the Travel Trainer from any liability pertaining to this training. I understand that there will be no financial or other remuneration for recording me in media used.

SIGN: _____ DATE: _____

OFFICE USE ONLY

Date MTT office submitted request or email _____

Date answered: _____

Dispatcher: _____

Request Accepted

Request Denied

If request denied, please state reason:

Appointment Scheduled: _____

Date: _____

Time: _____

Location: _____

NOTES: