



Mobility/Travel Training Program
TRAVEL TRAINING REQUEST FORM

810 Mission Ave • Oceanside CA 92054
 Phone: 760.966.6561 • Fax: 760.967.2001 • Email: ntrainer@nctd.org
 (All information will be kept confidential)

SECTION 1
 To BE COMPLETED BY APPLICANT: PLEASE FILL OUT THE FOLLOWING SECTION.

DATE: _____
 NAME: _____
 ADDRESS: _____
 CITY/STATE/ZIP: _____
 DOB/AGE: _____ MALE FEMALE
 TELEPHONE: () _____ CELL: () _____
 E-MAIL: _____

CONSERVATOR: PLEASE FILL OUT THE FOLLOWING SECTION.

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

SECTION 2
 To BE COMPLETED BY AGENCY/SCHOOL: PLEASE FILL OUT THE FOLLOWING SECTION.

AGENCY/SCHOOL NAME: _____
 CONTACT: _____
 ADDRESS: _____
 CITY/STATE/ZIP: _____
 TELEPHONE: () _____ CELL: () _____
 E-MAIL: _____

ADA ID#		CASE#		SCHOOL ID#	
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SECTION 3
 To BE COMPLETED BY APPLICANT/CONSERVATOR: PLEASE FILL OUT THE FOLLOWING SECTION.

1. Do you have a disability? Yes No If yes, please state disability: _____

2. Are you currently taking any medications? Yes No

If yes, please list current medications and state for what condition: _____

SECTION 3 CON'T

3. Do you use a mobility device? Yes No a) manual wheelchair b) scooter
 c) power chair d) other Please state: _____
4. Can you easily walk or propel your device from or to a location? a) 1-2 blocks b) 3 or more blocks
5. Can you wait at a bus stop for more than 15 minutes? Yes No
6. What is the usual form of transportation that you use? a) Personal vehicle b) Other drive me
 c) City buses d) Taxi cabs LIFT Other programs _____
7. How many bus routes are close to your home? _____ The route #'s are: _____

SECTION 4

TO BE COMPLETED BY APPLICANT/CONSERVATOR: PLEASE FILL OUT THE FOLLOWING SECTION.

1. **Type of training preferred:** Mobility Training Travel Training Both
If you have selected both training please complete the Mobility and Travel Training forms.
2. Point of interest/purpose for Mobility/Travel Training in North County: _____
3. Type of travel training desired: General use of NCTD services **Specific trip planning
**(i.e. traveling from home to a doctor's appointment, grocery store, post office, restaurant, parent's home, school, senior center, hospital or transit center)
- | Destination 1 | Destination 2 |
|----------------------|----------------------|
| To: _____ | To: _____ |
| Address: _____ | Address: _____ |
| City/State/Zip _____ | City/State/Zip _____ |
- Days available for Travel Training**
- _____
4. Will you have a Travel Buddy/PCA/Aide with you on your training: Yes No
- Name: _____ Signature: _____
- Address: _____
- City/State/Zip _____
- Phone: _____
5. Will you need a Flash Book: Yes No

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: _____