TRANSPORTATION SERVICE REGISTRATION FORM

1606 BETHANY RD, SYCAMORE, IL 60178
PHONE (815) 758-3932 FAX (815) 758-0202

Please Print Clearly and Fill in all Blanks

TODAY'S DATE _______________

NAME ____
(First) (Middle) (Last)

ADDRESS ____
(Street name and number) (Apt #) (City) (Zip Code) (Township)

PHONE ____ BIRTH DATE _______________________

SEX: Male ____ Female ____ NUMBER IN HOUSEHOLD _______

RACE:
____American Indian/Alaskan Native
____Asian/Pacific Islander
____Black, African American
____Hispanic
____White, Not of Hispanic Origin

LOW INCOME: Yes ______ No ______

ETHNICITY: ____ Not Hispanic or Latino
___Hispanic or Latino

DO YOU HAVE A MEDICAID MEDI-PLAN CARD? YES ____ NO ____
NAME (Exactly as it appears on the Medi-Plan Card) ____
MEDI-PLAN RECIPIENT NUMBER FROM BACK OF CARD (ID #) ____ ____ ____ ____ ____ ____ ____ ____ ____

DO YOU HAVE A DISABILITY? YES ____ NO ____

If Yes, Please Describe: ____
DO YOU USE: ___ Wheelchair ___ Cane ___ Service Animal
___ Motorized Scooter ___ Walker ___ Crutches
___ Portable O2
DO YOU HAVE A: VISUAL ______ OR HEARING ______ IMPAIRMENT?

DO YOU NEED ASSISTANCE WITH USING OUR TRANSPORTATION SERVICE: _____ Y _____ N
If Yes, Please Describe: ____

DO YOU HAVE AN ILLNESS OR ANY OTHER CONDITION THAT THE DRIVER SHOULD BE AWARE OF?
(For Example: Heart Condition, Asthma, Epilepsy, Cancer, Pregnancy, Etc.)
If Yes, Please Describe: ____
IN CASE OF EMERGENCY, PLEASE NOTIFY:
NAME ____RELATIONSHIP _______________________
ADDRESS ____PHONE _________________

____
(Signature)