



CITY OF PULLMAN

Pullman Transit and Dial-A-Ride

775 N.W. Guy Street, Pullman, WA 99163
Transit (509) 332-6535 Dial-A-Ride (509) 332-5471
Fax (509) 338-3247 www.pullmantransit.com
pullmantransit@pullmantransit.com

Temporary Dial~A~Ride Application

The information obtained in this certification process will be utilized for the provision of transportation services. This agency will not share your application with other transportation agencies or providers unless you request us to do so.

If you need help completing this application, please call Pullman Transit at 332-5471, or TDD Relay (800) 833-6388 or 7-1-1.

Name: Birth Date:

Street Address:

Home Phone: Work Phone:

E-Mail Address:

Are you a **WSU**: student staff faculty retiree none

I certify that the information I gave in this application is true and correct. Falsification of information may result in denial of service. I understand all healthcare information will be kept confidential except as needed for verification. Only the information required to provide services I request will be disclosed to those who perform those services. I have read and agree to comply with the policies and procedures set forth by Pullman Transit. I understand this document is a public record and may be subject to disclosure under RCW 42.17 upon request.

Applicant Signature **Date**

(If Applicant is a minor, or incapable of signing this application, please complete page 7)

From the following list please check any condition or disability that prevents you from using the fixed route bus service:

General Medical Conditions

- None Kidney Failure/Dialysis Diabetes
- Immunity Suppression Cancer Treatment

Other:

Heart and Circulatory Conditions

- None Peripheral Vascular Disease Stroke
- Edema Heart Attack
- Congestive Heart Failure Heart Surgery

Other:

Lung and Breathing Conditions

- None Emphysema Asthma
- Lung Cancer Cystic Fibrosis
- Chronic Obstructive Pulmonary Disease

Other:

Vision/Hearing/Speech Conditions

- None Dysarthria Blind
- Aphasia Cataracts
- Night Blindness Deaf
- Glaucoma Partially Sighted
- Hearing Impaired Diabetic Retinopathy

Other:

Developmental/Mental/Behavioral Conditions

- None Inability to Communicate/Nonverbal
-

Autism

Learning Disability

Explain:

Mental Disability: **Mild** **Moderate** **Severe**

Short Term Memory Loss

Thought Disorder/Confusion

Explain:

Aggressive toward:

Property **Other People** **Self** **Verbal Only**

Explain:

Difficulty Controlling Behavior

Explain:

Mood Disorder

Explain:

Phobia or Psychosis

Explain:

Bone and Joint Conditions

None

Arthritis

Rheumatoid Arthritis

Osteo-Arthritis

Osteoporosis

Fusion

Hip Disarticulation

Scleroderma

Prosthesis

Dwarfism

Broken Bone

Location:

Amputation: Location:

Other:

Brain/Nerves/Muscle Conditions

<input type="checkbox"/> None	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Amyotrophic
	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Cerebral Palsy
	<input type="checkbox"/> Dementia	<input type="checkbox"/> Epilepsy/Seizures
	<input type="checkbox"/> Friedreich's Ataxia	<input type="checkbox"/> Gullian-Barre
	<input type="checkbox"/> Huntington's Chorea	<input type="checkbox"/> Lateral Sclerosis
	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Muscular Dystrophy
	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Post-polio
	<input type="checkbox"/> Quadriplegia	<input type="checkbox"/> Spina Bifida
	<input type="checkbox"/> Vertigo/Dizziness	

Other:

Please explain as completely as possible how your disability prevents you from boarding, riding and exiting a regular fixed route bus.

How would you best describe your disability or condition as it impacts your transportation needs?

Permanent Deteriorating Changeable Temporary

If temporary, until what date:

Are there other effects of your disability or condition that we need to be aware of in order to provide you with appropriate service?

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Which of these aids or equipment do you usually use to help you get where you need to go?

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Electric Wheelchair | <input type="checkbox"/> Power Scooter |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Walker | Other: <input type="text"/> |
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Personal Care Attendant | |

Do you ever need the assistance of another person to be able to travel on Pullman Transit, either on the bus or Dial~A~Ride?

- Yes No Sometimes

When do you need help?

- Getting to/from vehicle Getting on or off the vehicle

What is the longest distance you can walk/travel on level ground without the assistance of another person? (Example 370 feet = 1 block)

Can you travel this distance in snow, ice, and uneven or steep ground?

- Yes No Sometimes, explain:

Please provide the name, address and contact information for your health care providers who can verify the information contained in this application. **(Your personal physicians name(s) go in this section.)**

Name:

Address:

City, State, Zip:

Phone: **FAX Number:**

(TO EXPEDITE APPL.)

Name:

City, State, Zip:

Phone: **FAX Number:**

(TO EXPEDITE APPL.)

I hereby certify that the information given above is correct. I authorize the release of my personal information to Pullman Transit for the purpose of verifying my information.

Signature of Applicant **Date**

If someone has completed this application other than the person applying for certification, that person must complete the following:

I certify that the information provided in this application is true and correct based upon my knowledge of the applicant's health condition or disability.

I certify that the information provided in this application is true and correct based upon information given to me by the applicant.

Signature: Date:

Print Name: Daytime Phone:

Address:

Relationship to Applicant:

Local Contact Person

This is a person who is authorized to make day-to-day and/or emergency decisions regarding service for the applicant. (In most cases this will be a provider or family member)

Name:

Address:

City, State, Zip:

Daytime Phone: Evenings:

Relationship: