# PERSONAL CARE ASSISTANT FORM

# APPLICANT – PLEASE COMPLETE THE TOP PORTION OF THIS FORM

Date:

Name of applicant:

 Last First MI

Address:

 Street City State Zip

Are you able to use the fixed route bus? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you require curb to curb service? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you require an escort when you travel? Yes \_\_\_\_\_ No \_\_\_\_\_

## PLEASE HAVE YOUR PHYSICIAN COMPLETE THE SECTION BELOW

The person’s disability can generally be described as (please print or type information):

\_\_\_\_\_ 1. The disability will last longer than twelve months

\_\_\_\_\_\_ 2. The disability is temporary and can be expected to last until \_\_\_\_\_ / \_\_\_\_\_

 Month Year

Under what conditions is an escort required?

Name of physician:

Address:

Phone No.:

Physician’s Signature:

**WHEN PROPERLY COMPLETED, PLEASE MAIL OR FAX TO**:

CUSTOMER SERVICE FAX NO. 717-848-4853

RABBITTRANSIT

415 ZARFOSS DRIVE

YORK, PA 17404