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: _________________________________________________________________

Telephone 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