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