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