Date Filed/Input:____________________

Community Transportation Program Registration

This form is required for all riders prior to using the transportation program. Please print all information and return to the Dispatch Office at 205 W. Livingston Road, Highland, MI 48357 or scan and email to: smartrides.hm@gmail.com.

NOTE: Disabled riders under age 55 must have a physician complete and sign back of this form. The dispatch phone number is 248-887-4979. Thank You.

Rider Information

Name:______________________________ Cell Phone #:______________________________

E-mail:______________________________ Home Phone #:______________________________

Street Address:______________________________________ Apt. or Bldg#:____________

City:________________________ Zip Code:________________

Mailing Address (If different from above):____

Birth date:____________________ Senior(55+):__________ Non-Senior:________

Emergency Contact Name(s):____

Phone #s:____________________________________ Relationship:____________________

Medical Information

Primary Physician:__________________________________ Phone #:____________________

Full Address:____

Do you require a Wheelchair Lift?: Yes❑ No❑

List any important medical or disability information that van drivers need to be aware of. For example, pacemakers, heart conditions, wheelchair use, walker, etc.,

____

____

____

****PLEASE NOTE:** Based on the status of our riders, if you are a regular rider and you are scheduled but you do not call to cancel your ride, you do not answer your phone and nor do you come out when the driver arrives, we reserve the right to call for a non-emergent welfare check to ensure your safety and well-being.*

I have read and understand the rules and regulations regarding the use of the Community Transportation Program. By signing this form, I acknowledge I will follow the rules and regulations of scheduling and riding the Commuity vans.

____________________________________ ____________________________

Signature of Rider Date

The following is for Disabled Riders under 55 years of age:

The individual named on the front of this form has a disability that, in my opinion, makes them a mobility-disabled individual. This disability is:

Permanent: Yes ☐ No ☐

Temporary: Yes ☐ No ☐ For a Period of: ____________________

Requires a Wheelchair Lift Assistance: Yes ☐ No ☐

______________________________ ______________________________
Signature of Physician Date

____
Printed Name of Physician

____
Full Address and Phone Number of Physician

Do Not Write Below - Office Use Only