



Senior Van Registration Form

Resident Information

Last Name:		First Name:	
Street Address:			Apt.
City:	County:	Zip:	Primary Phone: ()
Date of Birth:			
Primary Physician:		Physicians Phone: ()	

Disability Information

<i>Disability: A physical or mental impairment that substantially limits one or more major life activity</i>
Using the definition provided above, would you describe yourself as having a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use a wheelchair when you travel? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use an assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need assistance getting to and from the vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No

Emergency Contact Information

Last Name:	First Name:
Primary Phone: ()	Alternate Phone: ()
Relationship to Resident:	