



"Your Bridge To A Destination"

ST. JOSEPH COUNTY TRANSPORTATION AUTHORITY

810 Webber Avenue,
Three Rivers, Michigan 49093
Phone: 269-273-7808 / Fax: 269-273-8615
Email: www.sjcta@frontier.com

BUS RIDERSHIP REGISTRATION for DISABLED PERSONS

Please print) Name _____ Birth Date _____

Address _____ City _____

Zip code _____

Phone _____ Cell Phone _____

Gender – M F Ethnicity - _____ Number in Home _____ or Live Alone

Emergency Contact _____ Relationship _____

Phone 1 _____ Phone 2 _____

Please Check All Categories That Apply:

_____ Mobility Limited _____ Hearing Impaired _____ Respiratory

_____ Visually Impaired _____ Speech Impaired _____ Neurological

Aids Used (if any): _____ Wheelchair _____ Walker _____ Braces _____ Prosthetic Device

_____ Other _____ Attendant _____ Crutches or Cane _____ Service Animal

Is this a temporary disability _____ From _____ To _____

Do You Need the Lift Equipped Bus? Yes No Poverty- Yes No

What is Your Primary Language Spoken? _____

Applicant's Signature _____ Date _____

Guardian Signature, (for under 18 years of age) _____

37.123 ADA Paratransit eligibility: Standards

- 1) Any individual with a disability who is unable, as a result of a physical or mental impairment (including a vision impairment), and without the assistance of another individual (except the operator a wheelchair lift or other boarding assistance device), to board, ride, or disembark from any vehicle on the system which is readily accessible to and usable individuals with disabilities.
- 2) Any individual with a disability who needs assistance of a wheelchair lift or other boarding assistance device and is able , with such assistance, to board, ride, and disembark from any vehicle which is readily accessible to and usable by individuals with disabilities if the individual wants to travel on a route on the system during the hours of operation of the system at a time, or within reasonable period of such time, when such a vehicle is not being used to provide designated public transportation on the route.

I hereby certify that the physical condition of the handicapped person listed herewith constitutes him/her as a handicapped person as described under Section 37.123 of the ADA.

Physician's Signature _____ Physician's License Number _____

Physician's Name(PleasePrint)_____

Address _____ Phone _____

City _____ Zip Code _____

For office use only

Approved _____ Denied _____ Reason for Denial _____ Temporary _____

Approved By _____ Date: _____