



**SECTION C: DISABILITY INFORMATION**

**TO BE COMPLETED BY HEALTH CARE PROFESSIONAL** (Doctor, Nurse, Physiotherapist, Occupational Therapist, Recreational Therapist):

1. Are there conditions or special health care needs which would prevent the applicant's independent use of conventional transit? Please explain: \_\_\_\_\_

2. Status of Condition:  Permanent  Temporary: Estimated time in months \_\_\_\_\_

3. Does the applicant require the assistance of a Support Person (Personal Care Attendant) in order to travel on conventional public transit (HSR)?

Yes  No

**CERTIFICATION BY HEALTH CARE PROFESSIONAL**

Name of Health Care Professional (Please PRINT) \_\_\_\_\_

Professional Designation \_\_\_\_\_

Organization's Name \_\_\_\_\_

Address \_\_\_\_\_

Street Number and Name

Telephone

City

Province

Postal Code

Fax

I hereby certify that the information provided is accurate and complete to the best of my knowledge.

\_\_\_\_\_  
Signature of Health Care Professional

\_\_\_\_\_  
Date

Personal information on this form is collected under the authority of the *Municipal Act, 2001, S.O. 2001, c.25* as amended, and is used solely to determine eligibility for the Support Person Identification Card for travel on Hamilton Street Railway buses. This information is held in strict confidence. Questions about this collection should be directed to:

Accessible Transportation Services  
Attention: Customer Service Coordinator  
P.O. Box 340, 2200 Upper James Street  
Hamilton, ON L0R 1W0  
(905) 528-4200, Ext 1831

**\*\*FOR OFFICE USE ONLY\*\***

Date Approved \_\_\_\_\_

Comments: \_\_\_\_\_