Center Name: _____

TRANSPORTATION RELEASE AGREEMENT, WAIVER AND ASSUMPTION OF RISK

Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Insurance:** _____

Home #: _____ **Cell #:** _____

Emergency Contact #: _____ **Name:** _____

_____

Address Street **City** **State** **Zip Code**

Applicants Release:

I understand that the purpose of this evaluation form is to determine my eligibility for Orlando Family Physicians transportation services. I understand the information about my disability contained in the application will be kept confidential and shared only with professional involved in evaluating my eligibility. I understand that providing false or misleading information could result in my eligibility status being revoked. I agree to Notify Orlando Family Physicians within 10 days, if there are changes in my circumstances or I no longer require the transportation service. I understand I must live within 10 miles of physician office to be considered for transportation program.

As a part of the consideration for the provision of transportation services as provided herein, I hereby waive, release, hold harmless and forever discharge Orlando Family Physicians, its officers, directors, employees and agents from any and all liabilities, claim, demands or causes of action whatsoever arising out or relating to any loss, property damage, delay or personal injury, including death, that may be sustained by me or by any passenger for whom I am the legal guardian attributable to or in connection with said transportation services whether the same be caused by the negligence of Orlando Family Physicians, its officers, directors, employees, agents or any other person involved in providing same.

_____

Applicant/Legal Guardian Signature **Date**

_____

Witness **Date**

_____

Witness **Date**

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PLEASE READ CAREFULLY AND ANSWER THE FOLLOWING QUESTIONNAIRE:

Do you have friends or relatives who can take you to your destination? ☐ Yes ☐ No

Why do you need transportation assistance?

_____

How do you currently travel to your destination?

_____

Do you or anyone in your household have a car? ☐ Yes or ☐ No

Please check all that apply to you:

☐ I am on portable oxygen	☐ I use crutches
☐ I have s sight impairment	☐ I have a hearing impairment
☐ I use a cane	☐ I use a walker
☐ I have a personal care attendant	☐ I have a service animal
☐ I must travel by wheelchair	☐ I must travel by stretcher
☐ Scooter	☐ Leg Brace

I have a mental impairment. If so, please explain _____

Other (Specify) _____

Functional Ability:

Without the help of someone else, can you:

Read/hear/understand directions?	☐ Yes ☐ No	Balance while seated?	☐ Yes ☐ No
Travel one block on a sidewalk?	☐ Yes ☐ No	Cross a street?	☐ Yes ☐ No
Give you address and phone #	☐ Yes ☐ No	Climb a 12 inch step?	☐ Yes ☐ No

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Safety travel through crowded and or complex facilities? ☐ Yes ☐ No

Wait outside without support for 15 minutes or more? ☐ Yes ☐ No

Grip handles and railings? ☐ Yes ☐ No

Recognize a destination? ☐ Yes ☐ No

If you answered no to any of the above, please explain

_____

_____

_____

Are you enrolled in any other programs that will pay for or provide transportation? If yes, please describe them below.

_____

_____

FOR OFFICE USE ONLY:

Application Status:

☐ **Approved** **or** ☐ **Denied**

Orlando Family Physician Office Manager:

_____
Print Name

_____
Signature

_____
Date

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Orlando Family Physician Transportation Manager:

_____

Print Name

_____

Signature

_____

Date

Note: Application must be approved by both the Office Manager and Transportation Manager

Revised:4/2013