Code:_____

DIAL-A-RIDE APPLICATION

Mail or deliver application to:
PASADENA DIAL-A-RIDE, 221 East Walnut Street, Suite 199, Pasadena, CA 91101

Name: _____ Date of Birth: _____ ❒ Male ❒ Female

Address: _____ Apt. #:_____ Zip Code: _____

City: ❒ Pasadena ❒ Altadena ❒ San Marino ❒ Unincorporated L.A. County
(within our service area only)

Type of Residence: ❒ Individual ❒ Retirement/Senior Home ❒ Board & Care

Name of Living Facility (if applicable): _____ Phone No.:_____

Home Phone No: _____ Cell Phone No: _____

Email Address: _____

Age: ❒ 60+ ❒ Under 60 (with a disability)

Legally blind: ❒ Yes ❒ No

Disabled: ❒ Yes ❒ No (explain) _____

_____

Do you have an Access Services card? ❒ Yes ❒ No

I use the following: ❒ Walker ❒ Manual wheelchair ❒ Electric wheelchair ❒ Service animal

I speak: ❒ English ❒ Spanish ❒ Chinese ❒ Japanese ❒ Armenian ❒ Other

Only answer the following if you are 60 years or older:

Do you require a self-provided escort? ❒ Always ❒ Sometimes ❒ Not Required

EMERGENCY CONTACT INFORMATION:

Contact: _____ Relationship:_____ Phone:_____

I assume full responsibility for and release the City of Pasadena, the City of San Marino, and Los Angeles County from any liability for my safety and well-being before I board and after I exit the DIAL-A-RIDE vehicle.

SIGNATURE: _____ **DATE:** _____

Submit the following to process your DIAL-A-RIDE membership:

1) Completed Application

2) Copy of identification with your date of birth and residential address

3) Physician's Verification (only if under 60 years old)

IF YOU ARE UNDER 60 YEARS OF AGE YOU MUST HAVE YOUR PHYSICIAN COMPLETE THE PHYSICIAN'S VERIFICATION ON THE BACK SIDE (OVER)

Statistical Information - Optional

This information is voluntary. Please check one box only that you most closely identify with:

❒ Asian or Pacific Islander ❒ Native American or Alaskan Native
❒ Black (non-Hispanic) ❒ White (non-Hispanic)
❒ Hispanic ❒ Armenian

Code:_____

PHYSICIAN'S VERIFICATION – Part II of Application

(Only for disabled applicants under 60 years old)

This section must be completed by an authorized California Physician

Eligibility Evaluation:

Applicant's Name: _____ Date of Birth: _____

Indicate one or more of the following disabilities that prohibits the applicant from boarding and alighting regular public transit:

❒ Legally blind ❒ Kidney disease ❒ Developmentally Disabled

❒ Impaired by class III or class VI type cardiovascular disease as defined by the American Heart Association

❒ Suffers from lung disease such that measured forced respiratory volume for one second is less than 1L or arterial oxygen tension is less than 60 mm/Hg on room air at rest

❒ Other. Explain disabilities (**in detail**): _____

_____

_____

Does patient have an Access Services card? ❒ Yes ❒ No

Duration and Degree of Disability:

The patient's disability is: ❒ Permanent ❒ Temporary

If temporary, please indicate the length of disability:

❒ 2 months ❒ 4 months ❒ 6 months (*After 6 months, physician's re-verification is required)

Physician's Information:

Physician's Name: _____ License No.: _____

Business Address: _____

City: _____ St.: _____ Zip: _____ Phone: _____

I hereby certify that I am a licensed physician of the State of California, have knowledge of this applicant, and recommend that the applicant be certified to use the Pasadena, San Marino, Los Angeles County DIAL-A-RIDE because of the aforementioned disability which ***prevents the applicant from using regular transit services (Example: Metro, Foothill Transit, etc.).***

Does the applicant require a self-provided escort? ❒ Always ❒ Sometimes ❒ Not Required

What prevents the applicant from using regular transit services?

_____

_____

Physician's Signature: _____ Date: _____

- **Please fill out all blank lines and check all boxes that pertain to your application.**
- If you have any questions call the DIAL-A-RIDE administrative office at (626) 744-4094

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