ESCORT FORM

APPLICANT – PLEASE COMPLETE THE TOP PORTION OF THIS FORM

Date:
Name of applicant:
DOB:
Address:

Do you require an escort when you travel? **Yes _____** **No _____**

Do you require a wheelchair accessible vehicle? **Yes _____** **No _____**

PLEASE HAVE YOUR PHYSICIAN COMPLETE THE SECTION BELOW

The person's disability can generally be described as (please print or type information):

_____

_____

_____1. The disability will last longer than twelve months

_____ 2. The disability is temporary and can be expected to last until _____

Under what conditions is an escort required? _____

_____

Name of physician: _____

Address: _____

_____

Phone No: _____License No:_____

Physician's Signature_____

Please return completed form to:
GO Westmoreland
Fax: 724-853-2760
info@westmorelandtransit.com