The Corporation of the City of Kingston

APPLICATION FOR SUPPORT PERSON PASS

The completed application can be delivered or mailed to Kingston Transit, 1181 John Counter Blvd, Kingston, ON K7K 6C7
or faxed to (613) 542-1504

Part A - Applicant Information - To be completed by Applicant or Legal Guardian

☐ New Permit ☐ Renewal Permit

FOR OFFICE USE ONLY

Permit Number (if applicable)

Last Name of Applicant | First Name | Initial

Street No. and Name or Lot, Con. And Twp. | Apt. No.

City, Town or Village | Prov. | Postal Code

Date of Birth (Year / Month / Day) | Sex | Telephone No.

Signature of Applicant or Legal Guardian

Date (Year / Month / Day)

Part B - Health Information - To be completed by an Authorized Regulated Health Practitioner

Instructions: Health practitioners must complete Sections 1, 2 and 3 below, verifying that the applicant requires a support person in order to assist with communication, mobility, personal care or medical needs or with access to goods or services.

Section 1 Assessment of Health Conditions

☐ Any degree of physical disability caused by bodily injury, birth defect or illness

☐ Mental impairment and/or developmental disability

☐ Learning disability or dysfunction in one or more of the processes involved in understanding or spoken language

☐ Mental disorder

☐ Injury or disability for which benefits were claimed or received under the *Workplace Safety and Insurance Act, 1997*

Section 2 Status of Condition

Check only ONE condition

☐ Permanent

☐ Temporary Condition - Estimated length (in months)

Section 3 Regulated Health Practitioner

I certify that the applicant requires a support person or companion in accordance with the information in Sections 1 and 2.

Regulated Health Practitioner's College Number | Telephone No.

Year / Month / Day

Signature of Regulated Health Practitioner

Date

I am registered with:

☐ College of Physicians & Surgeons of Ontario

☐ College of Occupational Therapists of Ontario

☐ College of Physiotherapists of Ontario

☐ College of Chiropractors of Ontario

☐ College of Nurses of Ontario

☐ College of Chiropodists of Ontario

Please print or stamp name and address of Regulated Health Practitioner.

** Any health documents filed in support of this application are privileged - subject to the confidentiality provisions of the Municipal Freedom of Information and Protections of Privacy Act (MFIPPA).*

** This form is available in an alternate format upon request.*