

## REQUEST FOR SPECIAL TRANSPORTATION FOR MEDICAL REASONS

### Student Information

Student's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### To be completed by Doctor:

Name of Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
(please print)

Date of examination (on which this report is based):

What is the nature of the illness/ disability?

Please complete the following as they pertain to the patient's current limitations/ restrictions:

- a) MOBILITY: maximum walking distances with an assistive device: \_\_\_\_\_ meters
- b) VISUAL: is the patient's best corrected eye vision less than 20/ 200 or a field of vision less than 20%? Y / N
- c) AUDIO: is the patient's hearing less than 50 dB with the assistance of hearing aids? Y / N
- d) CARDIOVASCULAR: patient's impairment reaches class 3 or 4 definitions according to the Canadian cardiovascular standard? Y / N
- e) VENTILATION: patient's forced expiration volume in 1 second is less than 1 litre? Y / N
- f) OTHER (please specify):

Duration transportation is required:

Start: (m) \_\_\_\_\_ (d) \_\_\_\_\_ (y) \_\_\_\_\_      Finish: (m) \_\_\_\_\_ (d) \_\_\_\_\_ (y) \_\_\_\_\_

\_\_\_\_\_  
Signature of Doctor