



## SPECIALIZED TRANSIT – APPLICATION FORM

**Both Part A and Part B must be completed in order for your application to be considered.**

Please return the completed form to the address listed below.

**Service Provider – Landmark Transportation Ltd.**

1940712 o/a Landmark Student Transportation Ltd  
50 Sanford Fleming Road  
Collingwood, Ontario  
L9Y 4V7  
Phone: (705)446-1196  
Fax: 1(800)947-3839  
Email: [Reserve.ST@landmarkbus.com](mailto:Reserve.ST@landmarkbus.com)

**Specialized Transit service is intended for those persons who, due to a functional limitation, cannot board, ride or disembark from the respective Municipal Accessible Conventional Fixed-Route System.**

The respective Municipal Accessible Conventional Fixed-Route Transit buses are all Accessibility for Ontarians with Disabilities Act (AODA) compliant. Every bus has a wheelchair lift or ramp and tie-down locations to accommodate two wheelchairs or powered wheelchairs. Due to space restrictions, mobility scooters are not permitted on the accessible conventional transit buses.

In order to ensure that the service is available to those that need it, Specialized Transit applicants are required to demonstrate why they are unable to use the Accessible Conventional Fixed-Route Transit Service.

The information provided on this application is of a confidential manner, and is for the sole use of consideration of service on the Specialized Transit Systems in the Township of Clearview, Town of Collingwood and the Town of Wasaga Beach. It is protected from access by the Freedom of Information and Protection of Privacy Act, 1990.

This application is subject to review by the Municipal Transit Representatives and Service Provider and any other persons deemed appropriate at any time.

Approved applications will be effective for three (3) years.

If you have any questions or need assistance, please call the Service Provider, Landmark Student Transportation Ltd. at (705)446-1196.

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## HOW TO APPLY FOR SPECIALIZED TRANSIT SERVICE:

Fill out Parts A and B of this application.

Take or send the application (Parts A and B) to your health care professional to have Part B completed. Both Part A and Part B must be completed in order for your application to be considered.

Return the completed application (Parts A and B) in a sealed envelope to the Service Provider or respective Municipality to which the applicant resides.

The Service Provider will notify you of your eligibility. If we require additional information, you may be requested to provide us with more information about your disability and how it affects your use of the respective Municipal Accessible Conventional Fixed-Route Systems. The Service Provider and/or Municipality may also determine that you require a Support Person in order to use the Specialized Transit Service.

If you have not been notified within 14 days of submitting your application, please call us.

All information on this application form will be kept confidential.

**Failure to completely fill out the application will delay the application process.**

## Part A: Applicant Information (To be completed by the applicant)

Please type or print clearly

### 1. Contact Information

*First Name*

*Middle Name*

*Last Name*

\_\_\_\_\_

*House #*

*Street Name*

*Unit # (if applicable)*

\_\_\_\_\_

*Town*

*Province*

*Postal code*

\_\_\_\_\_

*Home Phone #*

*Daytime Contact #*

*TTY/TDD # (if applicable)*

\_\_\_\_\_

*E-mail address*

\_\_\_\_\_

### 2. Date of Birth

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

### 3. In case of emergency, please notify

Name \_\_\_\_\_

Relationship to you Contact \_\_\_\_\_

Telephone # \_\_\_\_\_

### 4. Bus Stop (Choose only one)

I can always get to and from a bus stop

I can never get to and from a bus stop

I can get to and from a bus stop only if (check all that apply)

I have a support person with me

I need to travel less than \_\_\_\_\_ meters to and from bus stop

I am familiar with the area

There are curb cuts along the route to the stop

There is a sidewalk

The ground is level or only slightly inclined

The path is free of ice, snow or debris

Other \_\_\_\_\_

**5. Waiting at a bus stop (Choose only one)**

I can generally wait outside at a bus stop

I cannot wait outside at a bus stop

I can wait outside at a bus stop only if (check all that apply)

There is a bench

There is a shelter

The wait is no longer than \_\_\_\_\_ minutes

Other \_\_\_\_\_

**6. Using Accessible Conventional Fixed-Route Transit Bus. (Choose only one).**

I can independently recognize my destination and leave the vehicle

I cannot independently recognize my destination and leave the vehicle

I can recognize my destination and leave the vehicle only if (check all that apply)

The driver announces my stop

Other \_\_\_\_\_

**7. I can ride the Accessible Conventional Fixed-Route Transit Bus only if (Check all that apply)**

I have a support person with me  I am familiar with the routes

Every bus stop on my route is accessible  A seat is available

Other \_\_\_\_\_

**8. Will you use any of the following when you ride Specialized Transit? (Check all that apply)**

Manual Wheelchair  Service Animal

Powered Wheelchair  Cane

Oxygen Bottle  White Cane

Mobility Scooter  Prosthesis

Walker  Communications Board

Hearing aid(s)  Crutches

Other \_\_\_\_\_

\*Mobility scooters are restricted to 0.76 m (30 inches) wide x 1.23 m (48 inches) long

**9. Do you require a support person when you travel?**

\_\_\_\_\_ Yes                      \_\_\_\_\_ No      If yes, please explain:

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**10. If you use a wheelchair or scooter can you transfer to a car or bus seat without assistance?**

\_\_\_\_\_ Yes \_\_\_\_\_ No      \_\_\_\_\_ Sometimes (please explain)

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**11. What is your disability and how does it affect your ability to use the Municipal Accessible Conventional Fixed Routes?**

(please provide any information that you feel would help)

**12. I hereby certify that to the best of my knowledge, the information given above is correct and I authorize the health care professional named on Part B to provide information to the respective Municipality and Service Provider.**

**If new information is received regarding a change in my functional ability, my eligibility status may be reviewed.**

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Signature of applicant

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Date mm / dd / yyyy

If you are NOT the applicant, but have completed this application the applicant's behalf you must provide the following information

*First Name*

*Middle Name*

*Last Name*

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*House #*

*Street Name*

*Unit # (if applicable)*

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*Town*

*Province*

*Postal code*

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*Home Phone #*

*Daytime Contact #*

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*Relationship to the Applicant*

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**Declaration: I certify that to the best of my knowledge the information given above is correct.**

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Signature

Date mm / dd / yyyy

**When you have completed Part A, take or mail Parts A and B to your health care professional.**

**When Part B has been completed, mail or deliver both parts A and B to the Service Provider or the Municipality in which you reside.**

## Service Provider

1940712 o/a Landmark Student Transportation Ltd  
50 Sanford Fleming Road,  
Collingwood, Ontario  
L9Y 4V7  
Phone: (705)446-1196  
Fax: 1(800)947-3839  
Email: [Reserve.ST@landmarkbus.com](mailto:Reserve.ST@landmarkbus.com)

## Partner Municipalities

### Township of Clearview

217 Gideon Street  
Stayner, ON L0M 1S0  
Phone: (705) 428-6230  
Fax: (705) 428-0288  
Email: [dperreault@clearview.ca](mailto:dperreault@clearview.ca)

### Town of Collingwood

97 Hurontario Street  
P.O. Box 157  
Collingwood, Ontario  
L9Y 3Z5  
Phone: (705) 445-1030  
Fax: (705) 445-2448  
Email: [townhall@collingwood.ca](mailto:townhall@collingwood.ca)

### Town of Wasaga Beach

150 Westbury Road  
Wasaga Beach, Ontario  
L9Z 2N8  
Phone: (705) 429-2540  
Fax: (705) 429-8226  
Email: [publicworks@wasagabeach.com](mailto:publicworks@wasagabeach.com)



## Part B: Doctor's Note or Health Document by your Health Care Professional

**Specialized Transit service is intended for those persons who, due to a functional limitation, cannot board, ride or disembark from the respective Municipal Conventional Fixed Route Systems.**

In order to satisfy Part B requirements, a Doctor's Note or Health document from a Licensed Health Care Professional is required. A Licensed Health Care Professional includes, but is not limited to a Physician, Optometrist, Therapist or Practitioner.

If there is any other effect(s) of the disability that Municipality and/or Service Provider should be aware of, the Licensed Professional should advise of the same in the aforementioned note or document.

*\*\* The Doctor's Note or supporting Health Document should also specify the expected duration if the disability is deemed temporary or conditional.*

Any document filed in support of this application are deemed privileged – subject to the confidentiality provisions of the Freedom of Information and Protection of Privacy Act.