



ACCESSIBLE SHUTTLE CLIENT REGISTRATION FORM

Client Information

Name: _____

Address: _____

Date of Birth: _____

Emergency Contact / Substitute Decision Maker

Name: _____

Relationship: _____

Phone No.: _____

Billing Information

Name _____

Address: _____

Phone No: _____

E-mail: _____

Payment Method: ☐ Direct invoice to facility
☐ E – Transfer (info@valleyprimecaregivers.ca)
☐ Cheque (pay to Valley Prime Caregivers)
☐ Credit/Debit card - call to inform or tap on the day
☐ Cash pay to driver (exact amount only)

Allergies or other medical conditions (please describe):

If resident of a facility, consent to access information obtained: Yes () No ()

Mobility Aid required

☐ Wheelchair ☐ Cane
☐ Scooter ☐ Walker