

# BR MEDIVAN, INC.

Passengers Full Name: \_\_\_\_\_

Sex:  M  F  Prefers not to disclose

Date of Birth: \_\_\_\_\_

Covid Status:  Pos  Neg  Not tested & No signs &/or symptoms of Covid disease

Weight in lbs: \_\_\_\_\_ (approx.) Height in foot & inches: \_\_\_\_\_ (approx.)

Level of Service/Space Type:  AMB  WCH  BARI WCH Has own Wheelchair:  Y  N

Special Instructions:

\_\_\_\_\_  
\_\_\_\_\_

# of Companions/Ride Along: \_\_\_\_\_

PICK-UP Location Name: \_\_\_\_\_

PICK-UP Address: \_\_\_\_\_

Unit, Apt #, etc.: \_\_\_\_\_

# of Stair Steps: \_\_\_\_\_

Pickup Phone Number: \_\_\_\_\_

Passenger's Phone Number: \_\_\_\_\_

Appointment Type: \_\_\_\_\_

Trip Date: \_\_\_\_\_

Pickup Time: \_\_\_\_\_ AM/ PM

Appointment Time: \_\_\_\_\_ AM/ PM

Return Time: \_\_\_\_\_ AM/ PM

DROP-OFF Same as PICK-UP Location?  Y  N

If Not, DROP-OFF Name: \_\_\_\_\_

Address: \_\_\_\_\_

Unit, Apt #, etc.: \_\_\_\_\_

# of Stair Steps: \_\_\_\_\_

Drop-off Phone Number: \_\_\_\_\_

**Method of Payment:**  Cash  Check  Zelle  Credit/ Debit Card (3% convenience fee will be added w/ card payments only)

**Name of Responsible Person/ Requestor:** \_\_\_\_\_ **Contact No:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



BR Medivan, Inc  
2353 Demartini Ln.  
Brentwood, CA 94513

PHONE 925-848-1715  
FAX 925-392-8589  
EMAIL brmedivan@att.net  
WEB SITE BRMEDIVAN.COM