WELLESLEY,

WILMOT AND WOOLWICH TOWNSHIPS
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MOBILITY ASSESSMENT FORM

PART B: Mobility Assessment Form

The following Mobility Assessment Form must be completed by a Physician, Registered Nurse (RN), Physiotherapist or Occupational Therapist.

Diagnosis of illness/disability: _____

Describe the impact of the illness/disability on the applicant's physical mobility:

_____

Describe the impact of the illness/disability on the applicant's cognitive ability:

_____

_____

Is the applicant physically able to climb or descent 3 steps? ___ YES ___ NO

Is the applicant physically able to walk 175 meters? ___ YES ___ NO

Is it expected that the applicant's physical mobility will improve? ___ YES ___ NO

Check the time period for which you recommend the applicant use specialized transit:

____ Temporary: specify anticipated END date _____

_____ Permanent: wherein the applicant's mobility is not expected to improve

I have fully assessed the mobility restrictions of _____ (applicant's name) as they relate to the Kiwanis Transit Eligibility Criteria and can affirm that the applicant:

- has a physical challenge
- has a temporary mobility impairment, such as a broken leg
- has a cognitive challenge

Please check with professional designation pertains to you:

_____ Physician _____ Registered Nurse ____ Occupational Therapist ____ Physiotherapist

Print Name: _____ Signature: _____ Date: _____

Phone Number: _____ Fax Number: _____