13C Industrial Drive, Elmira, Ontario N3B 2S1
Phone: (519) 669-4533 Toll-free: 1-800-461-1355
Fax: (519) 669-3124 info@k-transit.com
www.k-transit.com

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 which professional designation pertains to you:

_____ Physician _____ Registered Nurse ____ Occupational Therapist ____ Physiotherapist

Print Name: _____ Signature: _____ Date: _____

Phone Number: _____ Fax Number: _____