Travel Training Referral

Personal Information

Last Name _____ First_____ MI_____

☐ Female ☐ Male Date of Birth _____

Home Address

Street _____

City _____ State _____ Zip _____

Cell Phone _____ Additional Number _____

Email _____

Mailing Address (If different from above)

Street _____ City _____ State _____ Zip _____

Emergency Contact

Name _____

Phone _____ Relationship _____

How did you hear about the program? _____

Category of Disability:

☐ Intellectual/Developmental ☐ Physical ☐ Psychiatric
☐ Deaf or Hard of Hearing ☐ Blind or Low Vision ☐ Chronic Medical
☐ Autism ☐ N/A
☐ Other:_____

Do you use any mobility devices?

☐ None ☐ Crutches ☐ Support cane ☐ Walker
☐ Power scooter ☐ White cane ☐ Service animal
☐ Manual wheelchair ☐ Power wheelchair ☐ Other:_____

Do you have difficulties with?

Memory Problem: ☐ Short term ☐ Long term ☐ Communication difficulties

☐ Social/behavioral problems ☐ Difficulties following instructions
Seizures: ☐ Uncontrolled ☐ Controlled ☐ N/A
Medications: ☐ Yes ☐ No *If yes, list medications used?* _____

_____

Why do you want to have travel training?_____

_____

Have you ever traveled by bus?

☐ Yes ☐ No

How far can you walk or travel (if using a mobility aid) by yourself?

☐ <1 block ☐ 1 block ☐ 2 blocks (1/4 mile)

☐ 4 blocks (1/2 mile) ☐ 6 blocks (3/4 mile) ☐ >6 blocks

Is there a bus stop or train station within walking distance?

☐ Not sure ☐ Yes ☐ No

Are you able to safely cross streets on your own?

☐ Not sure ☐ Yes ☐ No

Destinations:

List two places you would like to travel to on the fixed route bus system.

_____

_____

Signature of applicant _____ Date _____

Print Name _____

Signature of person assisting applicant (If any) _____

Send completed referral to:

Access San Joaquin at P.O. Box 201010, Stockton, CA 95202
Tel: (209) 242-9965 | Fax: (209) 948-3024
Attention: Access San Joaquin
Email: access@sjRTD.com