



# TOWN OF SOMERS SENIOR & DISABLED TRANSPORTATION REGISTRATION FORM

## Passenger Information

Full Name:

\_\_\_\_\_  
*Last* *First* *M.I.*

Address:

\_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_  
*City* *State* *ZIP Code*

Telephone: \_\_\_\_\_

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

Do you have any medical conditions you would like us to be aware of?  
\_\_\_\_\_

Primary Care Physician

Name: \_\_\_\_\_

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

Please indicate if you currently utilize any of these medical devices:

- Wheelchair
- Walker
- Cane

Phone: \_\_\_\_\_

## Emergency Contact Information

Full Name:

\_\_\_\_\_  
*Last* *First* *M.I.*

Address:

\_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_  
*City* *State* *ZIP Code*

Primary Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

## Emergency Contact Information

Full Name:

\_\_\_\_\_  
*Last* *First* *M.I.*

Address:

\_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_  
*City* *State* *ZIP Code*

Primary Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_