

Brenner Escorted Transportation Application

THE PROGRAM COORDINATOR WILL BE IN TOUCH WITH YOU AFTER YOUR APPLICATION IS SUBMITTED

	DEMOGRAP	HIC I	NFORMA	TION	ı				
Name:				DOB:				Age:	
Street Address:				Apt #:					
City:			State:			Zip code:			
Home #:	Cell #:			Email:					
Spouse's Name:				Email:					
Emergency Contact (if other):				Phone:					
PHYSICIAN AND DISABILITY INFORMATION									
This information is to ensure safe transportation and in case of an emergency.									
Physician:		Phone:			Fax:				
Street Address:			Email:						
City:			State:			Zip code:			
Reason you require escorted transportation:				Е	Expected duration of disability:		oility:		
What type of equipment do you use? Cane Walker Seated Walker Wheelchair									
Do you require an additional escort? Yes No Reason:									
By signing this application, I am confirment that it is only used to determine me "Program"). I certify that all informat Social Service Agency ("JSSA") to obtain I agree to pay all fees associated with a services from the Program and JSSA at the Program, JSSA, JSSA's affiliates, a harmless for any and all claims, including or in any way associated with use of the	ming that I understy eligibility to partion contained on the eligibility informathe Program. I volund recognize that rend JSSA's officersing, but not limited	tand t ticipa his fo Ition f Intaril neithe dire I to in	that the in te in the rm is true from my de ly assume er the Prog ectors, em jury, harm	form Brer and octor the r gram ployen, dar	onner Esc correct. , social v isks asso nor JSS ees, age	corted I give worker, ociated A is a cents, and	Transporta my permis , or other h with receind ommon ca and volunted	ation Program (the ssion for the Jewish ealthcare provider. ving transportation rrier. I fully release ers and hold them	
Client Signature						Date			

Please send completed form to Diane Hays-Earp at dhaysearp@jssa.org, 301-770-8741 (fax), or JSSA Attn: Brenner Escort 6123 Montrose Road, Rockville, MD 20852