City of Sunrise Department of Leisure Services
Special & Community Support Services

Medical Transportation Registration

Name:_____

Address: _____Zip Code:_____

Building No._____ Apt. No._____ Name of Complex_____

Telephone No _____Marital Status_____

Date of Birth: _____Age:_____Do you have a vehicle in your household? ☐ Yes ☐ No

Do you use: ☐Wheelchair ☐Cane ☐Walker ☐Crutches ☐Scooter **OR** ☐None

☐Other (please specify) _____

Emergency Contact

Name:_____ Phone Number:_____

Additional Information If Necessary: _____

_____

Applicant Self-Certification

Please check box 1 or 2 below indicating the reason why you are seeking Medical Transportation

1 ☐ I hereby certify that I am at 62 years of age or older and currently a City of Sunrise resident.

OR

2 ☐ I hereby certify that I am under 62 years of age, have a physical disability and currently a City of Sunrise resident.

Please check the box below indicating that you received the Medical Transportation Guidelines.

☐ I hereby certify I have received and agree to follow the program guidelines

Applicant Signature: _____Date: _____

Please return completed forms to:
Sunrise Senior Center Attn. Medical Transportation
10650 West Oakland Park Boulevard
Sunrise, FL 33351
Or email to KOsborn@sunrisefl.gov

Official Use Only:

Registered by: _____Approved By: _____
Signature Signature

☐ Not Approved Reason:_____ ☐ Applicant Notified of Status ☐ Card Typed

Updated 01/22/2020 KO