Story County RSVP Offices
515-292-8890 (Ames)
515-733-4917 (Story City)

Client Registration Form
Central Iowa RSVP
Volunteer Driver Transportation Program

CONFIDENTIAL

CLIENT INFORMATION

Name: _____ **Date Registered:** _ _/_ _/_ _ _ _
First Last MI Mo Day Year

Birthdate: _ _/_ _/_ _ _ _ **Gender:** ☐ Male ☐ Female

Residential Address: _____ IA
(Do not use P.O. Box #) Street City State Zip

Mailing Address: _____
(If different from residential) Street City Zip

Home Phone #: **Cell Phone #:**

Email Address:

RIDES AND REFERRAL INFORMATION

How often do you anticipate requesting rides provided by RSVP volunteers? ☐ 1-2 times/week
☐ 1-2 times/month ☐ Less than 6 times/year ☐ Other (please explain): _____

List the main purposes and locations of your trips? (i.e., Dr. appts, physical therapy, etc.)

Were you referred to the RSVP Transportation Program by another agency or medical facility? ☐ Yes ☐ No

If yes, which agency/medical facility?

By Whom? Name: **Phone #:**

If not a referral, how did you learn about the program?

EMERGENCY CONTACT INFORMATION

Name: **Relationship:** **Phone #:**

Name: **Relationship:** **Phone #:**

Doctor/Clinic: **Phone #:**

Do you live alone? ☐ Yes ☐ No **If no, total in household** _____

SIGNATURES

I have been provided with the RSVP Volunteer Driver Transportation Program Conditions of Service and Guidelines for Rider Eligibility and agree to comply with all of the terms. I understand that the information provided on this registration form is confidential and will NOT be shared or used by RSVP except for the purpose of providing transportation services. I hereby agree to indemnify and hold harmless Central Iowa RSVP and it's participants, against any and all liability, loss, damage, costs or expenses which I may sustain, incur or be required to pay because of injury, death, or property loss or damage while being transported.

Participant Signature _____ **Date**_____

Interviewer Signature _____ **Date**_____