VIA Rail Canada

REQUEST TO TRAVEL WITH A SUPPORT PERSON

SECTION A: Passenger Consent
(To be completed by the passenger)

Passenger Information

Name of passenger: _____

Name of legal representative (if applicable): _____

Reservation number: _____

Email address: _____

Phone number: _____

Passenger consent

I understand that my personal information provided in this application will be used to handle my request and facilitate my transportation. I acknowledge that this information will be kept confidential in accordance with VIA Rail's Privacy Policy. In the case of a permanent functional limitation and unless I notify VIA Rail otherwise, I authorize VIA Rail to retain my application for a period of five (5) years from the date of signature of this application in order to use this information for all future trips and service requests. This way, I will not have to submit new documents for each of my trips, but I will have to submit a new form five (5) years after signing this application.

I agree to provide a valid medical certificate in the event of any significant change in my health and to abide by the terms of any medical accommodation, including attendant requirements and travel companion restrictions. I certify that the support person will be able to meet all my specific needs during my travels.

I HAVE READ AND UNDERSTOOD the terms of this agreement which I have signed voluntarily.

Signature: _____
(*Passenger or legal representative*)

Date [YYYY/MM/DD]: _____

SECTION B: Medical Certificate

(To be completed by the attending physician or authorized health care professional)

**(psychiatrist, psychologist or nurse practitioner)*

IMPORTANT NOTE TO THE PHYSICIAN OR AUTHORIZED HEALTH CARE PROFESSIONAL

If your patient requires assistance ONLY with baggage and boarding, do not complete this medical certificate. VIA Rail already offers these services free of charge to anyone with a disability without a medical certificate.

Physician or authorized health care professional's information

Name: _____

Phone number: _____

Fax number: _____

Adress of practice: _____

Physician's or health care professional's license number: _____

Patient's limitations

☐ I certify that my patient, whose name appears in Section A, requires travel with a support person

My patient's functional limitations are (Please check one of the boxes below):

☐ Permanent

☐ Temporary Duration* _____

**In the case of a temporary limitation, the attending physician or authorized health care professional must date and sign this medical certificate no sooner than one year prior to the date of scheduled travel with VIA Rail.*

By signing this medical certificate, I understand that VIA Rail will rely on my statement above, for my patient to be accompanied, during their travel(s) with VIA Rail, by a support person. Therefore, I certify that all the information provided is complete, true, and accurate and that I am authorized by my professional association to complete this medical certificate in my province and country of practice.

_____

Signature of attending physician or authorized health care professional

Title: _____

Date [YYYY/MM/DD]: _____