



Travel companion card request for regular exo transit network

Identification of person requiring a travel companion

Last name:	<input type="text"/>	First name:	<input type="text"/>		
Street number:	<input type="text"/>	Street:	<input type="text"/>		
Municipality:	<input type="text"/>	Province:	<input type="text"/>	Postal code:	<input type="text"/>
Telephone:	<input type="text"/>	Telephone (work):	<input type="text"/>		
Email:	<input type="text"/>				
Preferred title:	<input type="checkbox"/> Ms.	<input type="checkbox"/> Mr.	<input type="checkbox"/> Neutral	Date of birth (YYYY-MM-DD):	<input type="text"/>

*Identification of person completing and signing the form, if different

Last name:	<input type="text"/>	First name:	<input type="text"/>
Telephone:	<input type="text"/>	Telephone (work):	<input type="text"/>
Relation to applicant:	<input type="text"/>	Email:	<input type="text"/>

Agreement and signature of person requiring a travel companion

As the holder of an exo travel companion card (the “Card”), I agree to:

- Show the Card when paying one pass-through fees and any time an exo inspector requests to see it
- Inform exo of any address change
- Inform exo immediately if the Card is destroyed, lost or stolen
- Not allow anyone else to use the Card
- Return the Card to exo as soon as possible if it’s not being used
- Include a certified photo by a healthcare professional (approx. 3.5 cm x 3.5 cm)

Note: Only one companion at a time may travel for free with the person requiring a travel companion.
The travel companion is only entitled to travel for free when accompanying the person requiring a travel companion.

I certify that the information provided is accurate and I further authorize the healthcare professional to send the completed form to exo.

Signature of person requiring a travel companion, or their representative

Date (YYYY-MM-DD)

Declaration by healthcare professional

This section must be completed by a healthcare professional: a licensed physician, a registered nurse and/or nurse practitioner, a licensed occupational therapist, a licensed physiotherapist, a licensed psychologist or psychiatrist, or a licensed optometrist or ophthalmologist.

1. Are the functional limitations permanent? Yes No

If they are temporary, for how long?

2. Does the applicant require a companion to travel on the transit agency's regular network? Yes No

3. Specify the functional limitations that justify the need for a travel companion to use the transit agency's regular network

Difficulties with temporal awareness

Difficulties with spatial awareness

Problems with personal safety

Behavioural problems

Other disability, please specify:

Based on my assessment, I certify that the functional limitations of Ms./Mr.

justify the need for a travel companion when using the transit agency's regular network.

OR

Based on the evaluation report sent to me, I certify that the functional limitations of Ms./Mr.

justify the need for a travel companion when using the transit agency's regular network.

I certify that the person in the photo is the person who requires a travel companion. I have initialled the back of this photo.

Note: Certification fees shall be paid by the applicant, if applicable.

Name of healthcare professional

Occupation

Telephone

Professional address

Signature

Date (YYYY-MM-DD)

Please send this completed form and photo (if scanned: front and back) initialled by a healthcare professional to:

Accessibility Coordinator
700 De la Gauchetière Street West, 26th Floor, Montréal, Québec, H3B 5M2
Email: carteaccompagne@exo.quebec