exo | Réseau de transport métropolitain

Travel companion card request for regular exo transit network

Identification of person requiring a travel companion

Last name: First name:

Street number: Street:

Municipality: Province: Postal code:

Telephone: Telephone (work):

Email:

Preferred title: ☐ Ms. ☐ Mr. ☐ Neutral Date of birth (YYYY-MM-DD):

If you have an exo paratransit file number, please indicate it here:
You do not need to complete the rest of this form.
Please only put your signature at the bottom of this page.

exo file number :

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

Last name: First name:

Telephone: Telephone (work):

Relation to applicant: Email:

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)

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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: carteaccompagnement@exo.quebec