WICOMICO COUNTY HEALTH DEPARTMENT
CLIENT TRANSPORTATION REQUEST FORM

CLIENT INFORMATION:

LAST NAME:	FIRST NAME:
TELEPHONE NUMBER:	

MODE OF TRANSPORT:

☐ WHEELCHAIR, CAN TRANSFER	☐ WHEELCHAIR, CANNOT TRANSFER	☐ WALKER, NEEDS LIFT	☐ CANE, NEEDS LIFT

TRANSPORTATION INFORMATION:

DATE OF TRANSPORT:	ARRIVAL TIME:	RETURN TIME:
TRIP PURPOSE:		
PICKUP ADDRESS:		CITY, STATE AND ZIP
DESTINATION ADDRESS:		CITY, STATE AND ZIP
TOTAL # OF PASSENGERS:	OTHER INFO OR NEEDS (CARSEAT, BOOSTER SEAT, ETC.)	
RETURN ADDRESS:	☐ SAME AS PICKUP ☐ NONE ☐OTHER: _____	

****THE CLIENT IS TO CALL EASTERN TRANSPORT AT (410) 749-8294 THE DAY BEFORE TRANSPORT BETWEEN 9 AM & 12 PM FOR ESTIMATED PICK UP TIME. ANY APPOINTMENTS NOT CONFIRMED BY 12 PM WILL BE CANCELLED BY THE VENDOR AND APPOINTMENT WILL NEED TO BE RESCHEDULED WITH PROVIDER.**

REQUEST INFORMATION:

DATE OF REQUEST:	PERSON AUTHORIZING TRANSPORT:
PCA #:	PROGRAM NAME:

****REQUESTER IS TO FAX FORM TO EASTERN TRANSPORT AT (410) 749-0007 BY 12 NOON AT LEAST TWO BUSINESS DAYS PRIOR TO DATE OF TRANSPORT. ALSO FAX A COPY TO MEDICAL TRANSPORTATION AT (410) 219-2885 FOR BILLING PURPOSES.**

FOR TRANSPORTATION STAFF USE ONLY

MILEAGE:	**AMOUNT:**	**INVOICE#:**