**Pirate Access Application Form**

### Applicant Information

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>Apartment/Unit #</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Email</th>
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</table>

<table>
<thead>
<tr>
<th>Banner ID Number</th>
<th>Requested Start Date</th>
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</table>

**Student** □

**Staff** □ Other □ If other, explain

**Faculty** □ Visitor □

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**Please indicate all that apply:**

**Impairment:**

- □ Unable to walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or another assistive device.
- □ Other: __________________________________________________________________________

**Mobility Aids/Assistance**

- □ Crutches/Cane
- □ Personal Care Attendant
- □ Wheelchair
- □ Walker
- □ Boot/Brace
- □ Other: __________________________________________________________________________

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*I certify that my answers are true and complete to the best of my knowledge. I have read and will abide by the ECU Transit Pirate Access Policies and understand that any false or misleading information may result in revocation of privileges.*

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

*Signature required of all applicants*
Healthcare Provider Information
To be completed by the Healthcare Provider

Full Name: ________________________________ Date: ________________

Last First M.I.

Name of Facility: ________________________________

Address: ______________________________________

Office Address

City ______________________________________

Office Phone: ________________________________ Email: ________________________________

Duration of transportation services*: _________________________________________________________

# of weeks

*Temporary Authorization will terminate with the end of the academic semester.

Healthcare Provider Signature: ________________________________________________________________