HOPE HAVEN INTERNATIONAL MINISTRIES

1800 19TH STREET • ROCK VALLEY, IOWA 51247 U.S.A.

PLEASE PRINT OR TYPE

WHEELCHAIR REQUEST APPLICATION

PLEASE PRINT OR TYPE

Application Date: _____ Application #: _____

Applicant's Name: _____ (Last) _____ (First) _____ (Middle)

Street Address: _____ Country: _____

City: _____ State/Province: _____ Postal Code: _____

Phone #: _____ Fax #: _____ Email: _____

Date of Birth: _____ (Day/Month/Year) Age: _____ Sex: _____ Height: _____ (Indicate Inches or CM) Weight: _____ (Indicate Pounds or KG)

Type of Disability/Injury: _____

Additional Requests: ☐ Crutches ☐ Walker ☐ Grab Bar ☐ Commode ☐ Transfer Board ☐ Other: _____

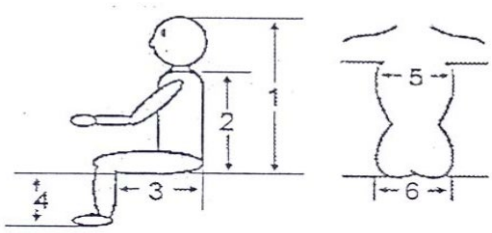
Can you sit without support? ☐ Yes ☐ No Can you self-propel? ☐ Yes ☐ No

Can you hold your head without support? ☐ Yes ☐ No Can you self-transfer? ☐ Yes ☐ No

Indicate missing limbs (X) or limbs without movement (M): ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

Patient's Measurements: (Indicate INCHES or CENTIMETERS)

#1 - Seat to Top of Head:	
#2 - Seat to Top of Shoulder:	
#3 - Upper Leg Length (seat depth):	
#4 - Lower Leg Length:	
#5 - Chest Width:	
#6 - Hip Width (seat width):	



When completing application, please affix a current photo of wheelchair applicant.

(BEFORE PHOTO)

HOPE HAVEN

After applicant receives wheelchair, please affix FOUR 3.5"x5" 35mm photos of person after properly seated in wheelchair.

(AFTER PHOTO)