

ClasTran

Group Trip Request

Please Print or Type!

Part I:

Date of Request: _____ Agency Requesting Trip: _____

Total Number of People Attending the Trip: _____
(include agency representative(s) if riding the ClasTran vehicle)

Date of Service: ____/____/____ Wheelchair accessible vehicle? Yes No

Center Name: _____ Center Address: _____

Contact Name: _____ City/Zip Code: _____

Phone: (205) _____ (# to reach contact person while on the trip)

Trip Details:

Requested Pick-Up Time at Center: _____ Requested Return Time to Center: _____

Request Drop off Time to Destination: _____ Requested Pick-Up Time at Destination: _____

Pick-Up Address: _____ Destination Address: _____

Pick-Up Phone #: (205) _____ Destination Phone #: (205) _____

Type of Trip: (Check One)

____ Shopping ____ Educational ____ Medical ____ Special Event ____ Other: _____

Special Instructions: _____

For ClasTran Use Only:

Part II:

Group Trip Confirmation

Date of Service: ____/____/____ Agency Representative: _____

Actual Pick-Up Time at Center: _____ Actual Return Time to Center: _____

Actual Drop off Time to Destination: _____ Actual Pick Up Time at Destination: _____

Checklist:

- | | |
|--|---|
| ____ Enter Date of Service | ____ Enter Total Number of People Attending |
| ____ Enter Wheelchair Accessible vehicle | ____ Enter Pick-Up Time at Center |
| ____ Enter Pick-Up Address/ Phone # | ____ Enter Drop off Time to Destination |
| ____ Enter Destination Address/Phone # | ____ Enter Pick Up Time at Destination |
| ____ Enter Type of Trip | ____ Enter Return Time to the Center |
| ____ Enter Contact Name/Phone # | ____ Enter Special Instructions |

Date Confirmation Faxed: ____/____/____ ClasTran Representative Signature: _____