



DIAMOND RIDE APPLICATION

Return in Person To:
City of Diamond Bar
21810 Copley Drive
Diamond Bar, CA 91765
www.diamondbarca.gov
Phone 909.839.7000

Instructions: Residents 60 years and older complete items 1-3 and 5, and sign on Page 2. Residents with disabilities complete items 1-5 and sign on Page 2.

1. General Applicant Information New Application Renewal (ID# _____)

Last Name: _____ First Name: _____

Address: _____ Apt #: _____

City: _____ Zip: _____

Home Phone: _____ Male Female Date of Birth: ____ / ____ / ____

2. Emergency Contact Information

Please list two contact people to be notified in case of an emergency.

Contact 1: _____ Contact 2: _____

Relationship: _____ Relationship: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

3. General Eligibility Information— Required

Driver’s License or government issued identification card showing proof of age and residency

4. Disability Eligibility Information — Provide one of the following:

Medicare Identification Card

California Department of Motor Vehicles Disabled Person Identification Card

Disabled Veterans Identification Card

Proof of SSI/SSDI Benefits (Copy of award letter, benefit adjustment, or benefit check)

Completed Medical Professional Certification may be submitted in lieu of one of the above listed certification documents

5. Certification — I hereby certify the information I have given in this application is correct.

Signature: _____ Date: _____

STAFF USE ONLY:

Application Complete Signed Waiver & Liability Form ID#: _____

Approved Denied Revoked — If Revoked, explain: _____

Signature: _____ Print Name: _____ Date: _____



WAIVER, RELEASE AND DISCHARGE OF LIABILITY

In consideration of my being permitted to enroll and participate in Diamond Ride (“said activity” herein) sponsored by the City of Diamond Bar, I hereby voluntarily waive, release and discharge in advance any and all actions or causes of action and claims for personal injury, property damage, or wrongful death which I may have, or which may hereafter accrue to me, my heirs or any other successors in interest as a result of my participation in said activity including activities incidental thereto, and for whatever period said activity may continue. This release is intended to the fullest extent permitted by law, to waive, release and discharge in advance the City of Diamond Bar and their respective elected officials, officers, employees and agents (hereafter “Discharged Parties”) from any liability for personal injury, property damage or wrongful death caused by any act or omission by such Discharged Parties.

I understand that serious and minor accidents occasionally occur during said activity and that participants occasionally sustain fatal or serious personal injuries and as a consequence I assume those risks and agree that under no circumstances will I or any of my heirs, assign or any other successors in interest prosecute any civil action or present any claim for personal injury, property damage or wrongful death against the Discharged Parties who, through negligence or otherwise, might otherwise be liable to me, or my heirs, or other successors in interest for damages.

I further agree, for myself and on behalf of my heirs and any other successors in interest, that in the event any claim for personal injury, property damage or wrongful death shall be prosecuted against the Discharged Parties or any of them, as a result of my participation in said activity, I shall indemnify and hold harmless the Discharged Parties from any and all liability, claims and/or wrongful death.

PRINT PARTICIPANT’S NAME: _____

SIGNATURE OF PARTICIPANT: _____

DATE: _____

MEDICAL PROFESSIONAL CERTIFICATION

City of Diamond Bar - Return by Fax to 909.861.3117



SECTION 1 – MEDICAL RELEASE CONSENT (REQUIRED FOR MEDICAL DISABILITY CRITERIA ONLY)

In connection with my application for a DIAMOND RIDE Identification Card, I hereby authorize

Dr. _____ to release to the City of Diamond Bar medical or other pertinent information reasonably necessary to verify my patient status and the designation of my disability category.

I realize that I have a right to receive a copy of this authorization. I understand that I may revoke this authorization at any time. Unless revoked, this form will permit the health care professional certifying my disability to release pertinent information for up to 60 days after the date appearing below.

Applicant Name (Print)

Applicant Signature

Date

SECTION 2 – MEDICAL PROFESSIONAL CERTIFICATION (FOR DOCTOR'S USE ONLY)

Qualified health care professionals who may certify disabilities include:

M.D. & D.O. — All impairments ① ② ③ ④ ⑤

AUDIOLOGIST — HEARING IMPAIRMENTS ⑤ ONLY

CHIROPRACTORS — MOBILITY IMPAIRMENTS ① ONLY

CLINICAL PSYCHOLOGISTS — MENTAL IMPAIRMENTS ④ ONLY

OPTOMETRIST — VISUAL IMPAIRMENTS ③ ONLY

PODIATRIST — MOBILITY IMPAIRMENTS ① ONLY

In order to certify an individual for the **DIAMOND RIDE** Identification Card you must agree to only certify, as eligible, those individuals who meet the criteria below.

I hereby certify that the applicant's Medical Disability Criteria is /are (CIRCLE ALL NUMBERS THAT APPLY)

① MOBILITY IMPAIRMENTS

③ VISUAL IMPAIRMENTS

⑤ HEARING IMPAIRMENTS

② PHYSICAL IMPAIRMENTS

④ MENTAL IMPAIRMENTS

In the space provided below, indicate in detail applicant's disability (**REQUIRED**)

In my professional judgment the applicant's disability is expected to continue for _____ # of years, _____ months.

I am legally licensed as a _____ in the State of California and under the penalty of perjury, I hereby declare that information provided is true and correct.

MEDICAL PROFESSIONAL INFORMATION

Full Name

License Number

Address

Suite

City

State

Zip Code

Telephone Number

Signature

Date

