REQUEST FOR AMTRYKE®
THEREAPEUTIC TRICYCLE APPLICATION
(To be filled out by parent/guardian!)

AMBUCS™
Creating Mobility and Independence For People With Disabilities

CHILD'S NAME: _____ AGE_____ DATE OF REQUEST _____

MAILING ADDRESS: _____PHONE #_____

CITY/ STATE/ ZIP: _____County_____

PARENT'S/GUARDIAN NAME: _____

PHONE #_____ Email: _____

ADDRESS:_____CITY_____ST_____ZIP_____

SECONDARY CONTACT NAME: _____PHONE_____

DIAGNOSIS OF CHILD:_____

TREATING THERAPIST'S NAME: _____TITLE/FIELD:_____

PHONE: _____EMAIL: _____

HOW DID YOU HEAR ABOUT THE AMTRYKE® THERAPEUTIC TRICYCLE? (CHECK ALL THAT APPLY)
_____ THERAPIST _____ WEBSITE _____ AMBUCS™ MEMBER _____*OTHER

*IF OTHER PLEASE SPECIFY WHERE: _____

AMTRYKE® DEMONSTRATION SITE, GIVE NAME/STATE: _____

**IS FINANCIAL ASSISTANCE NEEDED IN OBTAINING THE TRICYCLE? _____ YES _____ NO

*IF YES, HOW MUCH CAN YOU PAY? _____

I AGREE TO "RECYCLE" THE TRYKE FOR USE BY ANOTHER CHILD? __ YES

TELL US ABOUT YOUR CHILD: _____

_____

_____

_____

_____

If possible including a photo of your child will help us to obtain a sponsor for your child's AmTryke® tricycle.

I give my permission for my child's picture and personal information to be used in AMBUCS™ materials to help in obtaining a sponsor for the AmTryke® therapeutic tricycle.
Name: _____ Date: _____

****AmTryke® therapeutic tricycles are distributed based on available funds and need, and individual placements of AmTryke® therapeutic tricycles are at the discretion of the local chapters.**

Please mail or fax this application to: AMBUCS™ Resource Center
PO Box 5127 High Point, NC 27262
888-AMTRYKE * Fax: 336-852-6830

AMTRYKE REQUEST , ASSESSMENT FORM AND PARENT/GUARDIAN WAIVER MUST BE RECEIVED TO PLACE CHILD ON WISH LIST.