

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



RECIPIENT'S NAME: \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF REQUEST \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ PHONE # \_\_\_\_\_

CITY/ STATE/ ZIP: \_\_\_\_\_ EMAIL \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

**IF RECIPIENT IS UNDER 18 YEARS OF AGE PARENT'S/GUARDIAN NAME:** \_\_\_\_\_

PHONE # \_\_\_\_\_ Email: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**OR SECONDARY CONTACT NAME:** \_\_\_\_\_ PHONE \_\_\_\_\_

**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 THE RECIPIENT:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

*I give my permission for my or 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 RECIPIENT ON WISH LIST.**