



### DISABILITY CERTIFICATION FORM

In order to receive a reduced Passenger Fare, rider must be over the age of 60 or have a verifiable disability. A physician or certified Human Services Professional must complete this form.

Rider Name (First, MI, Last) \_\_\_\_\_

#### MEDICAL INFORMATION

**Primary Care Physician Name and Title:**

**Physician Phone Number:**

**Fax Number:**

**Medical Condition/Health Status of Applicant:**

#### DISABILITY AND ACCOMODATION INFORMATION

Is the individual able to drive?  YES  NO

Is the disability permanent?  YES  NO If no, expected duration of disability? \_\_\_/\_\_\_/\_\_\_

Specify limitations the individual's mobility and any relevant information about individual's functional limitations:

\_\_\_\_\_

\_\_\_\_\_

Is the individual able to handle money?  YES  NO

Is the individual able to keep balance while seated on a moving bus?  YES  NO

Can the individual use railings or handles?  YES  NO

Is the individual able to understand and follow directions?  YES  NO

*Specify the accommodations, including equipment aids, or services, required by the rider. Check all that apply.*

<input type="checkbox"/> <b>Manual Wheelchair:</b> Make _____ Model _____ Year _____ Weight of wheelchair _____ lbs	<input type="checkbox"/> <b>Walker</b> <input type="checkbox"/> <b>Service Animal</b> <input type="checkbox"/> <b>Prosthesis</b> <input type="checkbox"/> <b>Crutches</b> <input type="checkbox"/> <b>Cane</b> <input type="checkbox"/> <b>Portable Oxygen</b> <input type="checkbox"/> <b>Braces</b>
<input type="checkbox"/> <b>Powered Wheelchair:</b> Make _____ Model _____ Year _____ Weight of wheelchair _____ lbs	



Transit within Reach

Span, Inc.
1800 Malone St
Denton, TX 76201
940.382.1900

Form with checkboxes for Powered Scooter, Personal Attendant, and Other. Includes fields for Make, Model, Year, and Weight of wheelchair. Also includes a question about transferring to a seat with YES/NO options.

PHYSICIAN OR HUMAN SERVICES PROFESSIONAL CERTIFICATION

(Examples of licensed or certified human services professionals include: Medical Doctor, Psychiatrist, Psychologist, Social Worker, Rehabilitation Professional, Physical/Occupational Therapist, Physician's Assistant, Nurse Practitioner, Registered Nurse)

I certify that I am the physician or certified human services professional listed in the application. I further certify that the information provided in this application, including information regarding the rider's age, description of disability, and functional limitations is accurate.

Physician or Certified Human Services Professional Signature \_\_\_\_\_

Provider Phone \_\_\_\_\_ Date \_\_\_\_\_