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

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.

☐ **Manual Wheelchair:** Make_____ Model_____ Year_____ Weight of wheelchair _____ lbs	☐ **Walker** ☐ **Service Animal** ☐ **Prosthesis** ☐ **Crutches** ☐ **Cane** ☐ **Portable Oxygen** ☐ **Braces**
☐ **Powered Wheelchair:** Make_____ Model_____ Year_____ Weight of wheelchair _____ lbs	

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

☐ **Powered Scooter:** Make_____ Model_____ Year_____ Weight of wheelchair _____ lbs	☐ **Personal Attendant** ☐ **Other: _____** _____
Is individual able to transfer to a seat? ☐ **YES** ☐ **NO**	

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_____