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, Ml, Last) ____________________________________________________________________________

MEDICAL INFORMATION

Primary Care Physician Name and Title: _____________________________________________________________

Physician Phone Number: __________________________ Fax Number: __________________________

Medical Condition/Health Status of Applicant: _____________________________________________________

DISABILITY AND ACCOMMODATION 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

□ Powered Wheelchair:
Make____________ Model____________
Year__________
Weight of wheelchair ________ lbs

□ Walker
□ Service Animal
□ Prosthesis
□ Crutches
□ Cane
□ Portable Oxygen
□ Braces
<table>
<thead>
<tr>
<th>Powered Scooter:</th>
<th>Personal Attendant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make____________ Model____________ Year________</td>
<td>Other: ________________</td>
</tr>
<tr>
<td>Weight of wheelchair ________ lbs</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

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__________________________________________