Medical Verification Form

This form shall be completed by a **physician** licensed to diagnose your condition or disability and is able to provide the needed information that would help determine eligibility for ADA paratransit service. Incomplete forms will be returned.

Patient Information			
Patient First Name:	**MI:**	**Patient Last Name:**	**D.O.B.** ____/____/_____

Physician Information		
Physician First Name:	**Physician Last Name:**	**Title (DO, MD, etc.):**

Name of Practice:	**Medical License No.:**

Street Address:	**City:**	**ZIP Code:**

Cognitive/Neurological: □ Cerebral Vascular Accident (Stroke) □ Neurological Handicap □ Dementia □ Alzheimer □ Developmental Disability □ Autism: □ Moderate □ Severe □ Profound □ Mental Illness □ Cerebral Palsy	**Physical Health:** □ Impaired or assisted ambulation □ Pulmonary: Portable Oxygen Tank? □ Yes □ No □ Cardiac □ Seizures □ Kidney Disease □ Arthritis, specify: _____
Sensory: □ Legally Blind □ Severely Visually Impaired □ Deaf □ Hard of Hearing	**Other/Not Listed:** □ Other, specify: _____

Please describe how the severity of all conditions, marked above, functionally prevents the applicant from using SARTA's fixed route (traditional city lines) lift equipped buses.

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I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis of disability listed above has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named on this form.

Signature _____ **Date:** _____/_____/_____

The **original** Medical Verification Form must be received within 30 days of the ADA Paratransit Application. Applications will only be considered completed if both the ADA Paratransit Application and Medical Verification Form are received. Copied, faxed, or scanned forms will not be accepted. Incomplete forms will be returned.