

MEDICAL VERIFICATION
(TO BE COMPLETED BY A LICENSED PHYSICIAN)

Date: _____

Patient's Name: _____

The person named above is ___ currently being treated or ___ was formerly treated by me. The person has informed me of his/her intent to apply for SARTA's Proline Service. The information provided in this form is intended to verify any medical/health conditions that prevent the applicant from using SARTA's Fixed Bus Route services.

1. Please indicate nature of applicant's disability (**check all that apply**)

- Impaired or assisted ambulation: Specify mobility aid: _____
- Arthritis: Specify extremity: _____
- Cerebral Vascular Accident (Stroke)
- Pulmonary: Does applicant travel with Portable Oxygen Tank? Yes No
- Neurological Handicap Cardiac Kidney Disease
- Legally Blind Severely Visually Impaired Alzheimer's
- Dementia Mental Retardation (indicate one) Cerebral Palsy
- Autism Moderate Severe Profound
- Deaf/Hard of Hearing: Specify nature of: _____
- Seizures Mental Illness Other _____

2. Please describe all conditions and severity (physical, cognitive, emotional, other), which functionally prevents the applicant from using SARTA's Fixed Route lift equipped buses.

3. How does this condition prevent the applicant from using SARTA's lift equipment fixed route bus service?

This section must be completed for application to be considered complete.

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Signature _____ Date _____

Print Name _____

Professional Title _____

State of Ohio License No. _____

Clinic/Agency _____

Address _____

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.