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:**

Date of applicant's last visit: ______________________

Medical diagnosis of disability/condition:

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Please describe in detail the impact this disability/condition has on the applicant's ability to use SARTA's Fixed Route services:

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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.

Physician's 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