DISABILITY VERIFICATION FORM: TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

A Healthcare Professional includes a clinical social worker, occupational therapist, physical therapist, rehabilitation specialist, medical physician, registered nurse, psychologist, psychiatrist, or similar professional duly licensed to practice in the State of California.

I certify that _____ qualifies for R-Transit service under the following categories *(check all that apply)*:

☐ The applicant by reason of illness, injury, congenital malfunction or other permanent or temporary incapacity of disability, is unable without special facilities or special planning to utilize the city bus system as effectively as a person who is not so affected.

☐ The applicant has a physical, cognitive, or mental disability which clearly demonstrates that the person experiencing such disability is unable, without difficulty or assistance, to utilize the city bus system.

☐ The applicant has an incapacity or disability which results in the ability to perform one or more of the following functions necessary for the effective us of the city bus system's facilities without significant difficulty (check all that apply):

- ☐ Negotiating a flight of stairs, escalator or ramp;
- ☐ Boarding or alighting from a city transit bus;
- ☐ Standing without major support in a moving vehicle operating under normal acceleration and deceleration;
- ☐ Due to uncorrectable visual impairment, this person cannot read transit vehicle identifications or identify transit stops;
- ☐ Due to uncorrectable hearing impairment, this person cannot hear verbal announcements or transit information through either direct person or electronic communication; or
- ☐ Walking more than 200 feet;

☐ For valid medical reasons, the applicant needs the aid of a cane, crutches, or other mechanical device to assist him or her in moving about.

This portion must be completed. The applicant's functional limitation(s) can generally be described as (i.e non-ambulatory, amputation, etc.):

_____

_____

Length of Disability: ☐ Permanent OR ☐ Temporary for _____ months

I certify that the statements contained herein are true and that the individual named in this document is receiving treatment/services from me/this agency.

Medical Facility Name: _____ **Healthcare Provider type:** _____
(i.e Kaiser, Alta Bates, Lifelong Medical Care) (i.e. physician, physical therapist)

Healthcare Provider Name: _____ **Provider License No:** _____
Print Name

Signature of Healthcare Provider: _____ **Date:** _____

Medical Stamp: _____ This form in invalid without a stamp from Medical facility/provider