ADA COMPLEMENTARY PARATRANSIT & TD ELIGIBILITY MEDICAL VERIFICATION FORM

Last Name | First Name | MI | Date of Birth

Medical Professional's Info

Name of Medical Professional | Title

Office address | Suite #

City | State | Zip Code | License #

Please list the applicant's disabilities/impairments

Are these permanent? ☐ Y ☐ N If not, how long is recovery expected to be:

According to your diagnosis and medical opinion can the applicant do any of the following?

Use the fixed-route system independently	☐ Y	☐ N	See bus signs, stops, and traffic signs	☐ Y	☐ N
Walk to the bus stop	☐ Y	☐ N	Understand how to use the bus (fares, wayfinding)	☐ Y	☐ N
Wait for the bus	☐ Y	☐ N	Transfer from one bus to another at a transfer point	☐ Y	☐ N
Board the bus with assistance of a ramp or kneeling bus	☐ Y	☐ N			

Does the applicant require any of the following mobility aids?

Powerchair	☐	Powered scooter	☐	Cane	☐	Braces	☐
Wheelchair	☐	Walker	☐	Crutches	☐	Oxygen	☐

In signing, I acknowledge that, to the best of my knowledge, the information in the form is true and correct. Furthermore, I certify that objecting medical testing/documentation that substantiates the diagnosis is part of the client's medical records. I understand that providing false or misleading information could affect the eligibility of the client and may result in prosecution to the maximum extent allowed by the laws of the State of Florida.

Signature | Phone Number | Fax | Email

If you are applying for service due to a medically verified physical or cognitive condition, impairment, or disability this MEDICAL VERIFICATION FORM must be completed and signed by a licensed medical professional.

Acceptable medical professions include:

- Medical Doctor
- Doctor of Osteopathic Medicine
- Doctor of Chiropractic
- Audiologist
- Ophthalmologist
- Psychologist
- APRN/PA
- Occupational/Physical Therapist
- Licensed Clinical Social Worker

For the medical professional:

In order to process this applicant's request for ADA Complimentary Paratransit or Transportation Disadvantaged services we require this form to be completed. Only licensed medical professionals having knowledge of the applicant's functional ability to independently use the fixed-route bus service should complete this form.

Please return the completed MEDICAL VERIFICATION FORM to the customer, mail, fax, or email to the mobility coordinator at:

Mobility Coordinator

5303 Pinkney Ave

Sarasota, FL 34233

Fax: 941-861-1007

Email: eligibility@scgov.net