PROFESSIONAL VERIFICATION (REQUIRED)

To The Applicant - Please have this page completed by a professional before mailing your application to SacRT. Any one of the professionals listed below may sign the application. If this page is not completed and signed by one of the professionals listed below, the application will be returned to you and processing will be delayed.

↪ MUST BE COMPLETED BY A PROFESSIONAL, NOT THE APPLICANT ↩

To the Professional - Please check your professional title:

❒physician ❒physician's assistant ❒registered nurse/nurse practitioner

❒psychiatrist ❒psychologist ❒social worker

❒chiropractor ❒physical therapist ❒occupational therapist

❒certified orientation & mobility specialist ❒speech-language pathologist

Eligibility criteria for the Americans with Disabilities Act (ADA) paratransit service is established by the ADA and is based upon an applicant's functional ability (not difficulty or inconvenience) to independently use SacRT's fully accessible bus and/or light rail system, some or all of the time. Factors not considered are the person's lack of knowledge of, or distance from transit, ability to drive, language or age. The information you provide will assist in determining under what circumstances this applicant may be eligible for ADA paratransit service.

Name of Applicant: _____ DOB _____

SPECIFIC DETAILS ON EACH DIAGNOSIS MUST BE PROVIDED OR APPLICATION WILL BE RETURNED:

Please list *each medical diagnosis* which prevents the applicant from independently using a lift-equipped bus or light rail train some, or all of the time.

_____

_____

_____

Please explain how the applicant's disability prevents them from using the regular bus and/or light rail system.

_____

_____

_____

Is this condition temporary? ❒ No ❒ Yes; for**:** _____ months

This person ❒ is ❒ is not **able to self-supervise daily activities**

I certify under penalty of perjury under the laws of the State of California that the information contained in this professional verification form is true and correct.

Signature_____ **Date** _____ /_____ /_____*

Printed Name_____ **Phone**_____

Clinic/Agency_____ **Address**_____

City _____ **State** _____ **ZIP**_____

Professional License/Registration/Certification#_____ **State**_____

This form expires 90 days from the signature date.

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Name of Applicant: *Jane Doe* **DOB** *11/04/1946*

SPECIFIC DETAILS ON EACH DIAGNOSIS MUST BE PROVIDED OR APPLICATION WILL BE RETURNED:

Please list *each medical diagnosis* which prevents the applicant from independently using a lift-equipped bus or light rail train some, or all of the time.

Gout, diabetes, stroke with right sided weakness, bipolar disorder, mild intellectual disability

Please explain how the applicants disability prevents them from using the regular bus and/or light rail system.

Limited walking distance, imbalance when walking, manic episodes impair judgement, unable to learn routes due to intellectual disability

Is this condition temporary? ☑No ❒ Yes; for: _____ months

This person ☑is ❒ is not **able to self-supervise daily activities**

I certify under penalty of perjury under the laws of the State of California that the information contained in this professional verification form is true and correct.

Signature _____ **Date** *04 / 10 / 13* *

Printed Name *Dr. William Smith* **Phone** *(916) 555-1234*

Clinic/Agency *ABC Clinic* **Address** *1234 7th Avenue*

City *Sacramento* **State** *CA* **ZIP** *95814*

Professional License/Registration/Certification# *A77777* **State** *CA*

***This form expires 90 days from the signature date.**