PROFESSIONAL VERIFICATION FORM

Part 1 Disability Verification: (To be completed by a physician, social worker, healthcare professional, or rehabilitation professional.)

YES	NO	
☐	☐	Does this patient have a disability? If YES please provide diagnosis in the space below.
		_____
		_____
		_____
☐	☐	If disability is cognitive or psychiatric in nature, please provide DSM-IV diagnosis.
		_____
		_____
☐	☐	Does this person travel with a comfort animal?
☐	☐	Does the person take medication that is contraindicated by exposure to direct sunlight and/or heat?
☐	☐	Does this patient have a visual impairment? (Please provide visual acuity) ☐ /
☐	☐	Does this person travel with a service animal?

Part 2 Key Functional Ability:

Please describe how this person's disability prevents them from using the regular bus system (i.e. Can the applicant get on/off the bus, is the applicant capable of making a transfer, is their mobility or endurance impaired in any way, can the applicant travel independently, read a schedule or recognize landmarks).

_____
_____
_____

Part 3 Assistive Devices & Equipment:

What type of mobility aid does this person use to travel within the community? *(Check all that apply)* →

If this patient is using a wheelchair/scooter, please provide total combined weight of person and mobility device. _____ **Lbs.**

- ☐ Manual Wheelchair
- ☐ Power Wheelchair
- ☐ Cane
- ☐ Walker
- ☐ Oxygen
- ☐ Other

Part 4 Signatures:

Health Care Professional Name and Title: _____
Business Address: _____ City/State Zip Code: _____
Telephone Number: ( ) _____
Signed: _____ Date: _____

I authorize the above professional to furnish RTS and the Center for Independent Living with information necessary to certify my eligibility:
Patient/Applicant's Name: _____
Social Security Number: _____ Date of Birth: _____
APPLICANT Signature: _____ Date: _____