



PROFESSIONAL VERIFICATION FORM

CIL STAFF: _____

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/description** below.

 If disability is cognitive or psychiatric in nature, please provide DSM-V diagnosis.

 Does this person travel with a comfort animal?

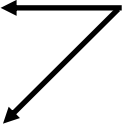
 Does the person take medication that is contraindicated by exposure to direct sunlight and/or heat?

 Does this patient have a visual impairment? (Please provide visual acuity)

_____ / _____

 Does this person travel with a service animal?

PLEASE PROVIDE DETAILS HERE.



Part 2 Key Functional Ability: This information will help determine eligibility.

YES NO

 Can the applicant get on/off the bus and make transfers?

 Is their mobility or endurance impaired in any way? Explain: _____

 Can the applicant travel independently, read a schedule or recognize landmarks?

 Does the person have difficulty being around other people ? (PTSD, Anxiety, Mood Disorder)

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: _____

PLEASE COMPLETE, DATE, AND SIGN HERE.



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: _____

Last 4 of Social: _____ Date of Birth: _____

APPLICANT Signature: _____ Date: _____