*****PHYSICIANS CERTIFICATION FOR SPECIALIZED TRANSPORTATION*****

To be eligible for Paratransit service individuals must be:

1. Any individual with a disability who is unable; as the result of a physical or mental impairment (including a vision impairment) and without the assistance of another individual (except the operator of a wheelchair lift or other boarding device), to board, ride, or disembark from any vehicle on the system which is readily accessible by individuals with disabilities.
2. Any individual with a disability who has a specific impairment related condition which prevents the individual from traveling to a boarding location of from a disembarking location on such system.

For an individual whose medical condition does not hamper his/her ability to walk and board a regular MTS bus, please recommend the individual apply for the reduced fare program for the disabled or senior citizens.

Medical Diagnosis: _____

(To be completed by physicians only)

Name of Patient: _____

This is a temporary _____ permanent _____ condition.

Transportation Requirement (Please check once):
_____ Curb to curb service, lift equipped for wheelchair.
_____ Curb to curb service, lift equipped due to limited physical ability.
_____ Curb to curb service, but lift equipment not necessary.
_____ Fixed route bus service with lift equipment will be adequate.

Further Comments:
If your patient uses a wheelchair, is he/she confined to this wheelchair or is he/she able to travel without the use of a wheelchair? _____

Does your patient have seizures? If yes, what type? _____

Does Patient have any condition such as:
_____ heart disease _____ diabetes _____ allergies _____ asthma
_____ other, please specify: _____

Does patient require personal care attendant? _____

Physician's Signature _____

Physician must sign (stamp not accepted)

Address: _____

City _____ State _____ Zip Code _____

Phone Number _____

The Middletown Transit System and its disabled passengers appreciate your consideration and help in making Paratransit service available to those who need it most and have no other transportation available to them. If you have any questions, please call MTS off ice at 727-3643.

*****TO BE COMPLETED BY APPLICANT*****

Last Name First Name Middle Phone

Street Address City State Zip

Daytime Phone Evening Phone Phone of Friend or Relative

1. What is your disability? _____
2. Do you have a wheelchair? NO _____ YES _____ What Type? Electric _____ Manual _____
3. Do you use walking aids? NO _____ YES _____ Crutches _____ Cane _____ Walker _____
4. Do you have an MTS reduced fare card for the disabled or senior citizen card? Please indicate which.
   Senior Citizen Card_____ Disabled Card _____
5. Do you use bus service now? NO _____ YES _____
6. Please provide any information about your transportation requirements that MTS may need to know. List any conditions your bus operator should be aware of. Please specify.

7. Physician: _____ Phone _____

Preferred Hospital _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Relationship _____ Phone _____

It is a requirement of the MTS program that you provide our office with an alternative address where we may take you in case of emergency. The address may be a friend, relative, or neighbor.

Drop off Address: _____

Name and Phone Number: _____

NOTE: Both the applicant's portion and the physician's portion of this application form must be competed when returned to the MTS office. If the form is not completed, our office will return this form to the applicant to be completed.

I certify that the above information is true and correct. I understand any mis-information could lead to canceling of my privilege to ride MTS Paratransit service. I will use other means of transportation whenever possible, making more space available for those who do not have a second choice due to the severity of their handicap.

Passenger Signature: _____ Date: _____

(If under 18, parent or guardian must sign)