Part 2. Professional Verification

Applicant's Name _____
Address _____
City/State/Zip _____

1. What is the diagnosis of the applicant's disability? Please describe specifically as possible in layman's terms. _____

_____

_____

2. Does the applicant's condition prevent him/her from using regular bus service?

☐ No ☐ Yes If yes, tell us why _____

_____

_____

3. Is the applicant's condition temporary? ☐ Yes ☐ No
If yes, expected duration is _____months.

The following information will be used to ensure the appropriate type of vehicle is used to provide transportation, and an accurate analysis of the applicant's trip request is processed by the RTA.

4. Does the applicant use any mobility aids? ☐ Yes ☐ No
If yes, what type? ☐ Wheelchair ☐ Scooter ☐ Walker ☐ Crutches ☐ Cane
☐ Other_____

5. Can the applicant be transferred from wheelchair/other mobility aid to a passenger seat if necessary? ☐ Yes ☐ No

6. Does the applicant need a Personal Care Attendant (PCA) for travel?
☐ Yes ☐ No
7. Can the applicant travel 200 feet without assistance? ☐ Yes ☐ No

8. Can the applicant travel one-quarter mile without assistance?
☐ Yes ☐ No
9. Can the applicant climb three twelve inch steps without assistance?
☐ Yes ☐ No
10. Can the applicant wait outside without support for thirty minutes?
☐ Yes ☐ No

11. Is applicant able to give address and phone numbers upon request?
☐ Yes ☐ No

12. Is applicant able to recognize a destination or landmark?
☐ Yes ☐ No

13. Is applicant able to deal with unexpected situations or unexpected changes in routine? ☐ Yes ☐ No

14. Is applicant able to ask for, understand, and follow directions?
☐ Yes ☐ No

15. Is applicant able to travel, safely and effectively, through crowded and/or complex facilities? ☐ Yes ☐ No

16. Can applicant use regular bus service if travel training is provided?
☐ Yes ☐ No

Please check only one of the following:

☐ Applicant can use regular public transit buses.
☐ Applicant cannot use regular public transit at all.
☐ Applicant can use regular public transit only to destinations for which applicant has been trained.

The Regional Transit Authority's paratransit program is a federally assisted program. By signing this document, the below-named licensed health care professional hereby certifies to the truth and accuracy of the above information to the best of his/her professional knowledge, information, and belief under the penalty of applicable federal, state and local law.

Print:

Health Care Professional's Name _____

Office Street Address _____

City _____ State _____ Zip_____

Office Telephone # _____ La Professional License # _____
(*Required*)

Signature _____Date _____

Please check the one that applies to you:

☐ Physician ☐ Vocational Rehabilitation Counselor
☐ Other: _____