***PROFESSIONAL VERIFICATION FOR** _____

Patient's Name

This verification will assist in determining if applicant is unable to ride the regular fixed route bus system and therefore eligible for UpLift Paratransit (ADA Disabled) bus service for all or some trip requests based upon his/her functional ability.

Note: All RTA' regular fixed route buses are low-floor buses equipped with ramps to accommodate persons with wheelchairs or those who cannot climb stairs. The definition of a fixed route bus is a bus that travels on a fixed route with a set time schedule. Whereas, UpLift buses are smaller buses that are wheelchair ramp buses that transport only those passengers that are ADA disabled and unable to ride the fixed route bus system. UpLift bus service requires reservations and is operated on a demand–responsive, origin-to-destination basis with the basic mode being curb-to-curb service.

All information will be kept confidential. Thank you for your assistance.

Capacity in which you know the applicant: _____

Is applicant able to travel on a fixed route bus that is wheelchair accessible or do they need the Access Express Bus?

____YES, Fixed Route Bus ____ NO, UpLift Bus*

*If no, what is the functional impairment that would prevent applicant from traveling on the fixed route bus?

_____

_____

_____

Is applicant able to get to or from the bus stop with any type of mobility aid? ____ YES ____ NO*

*If no, what is the functional impairment?

_____

Is this condition temporary? _____ NO _____ YES, for _____ months

_____ I have reviewed all of the information contained in this application, and hereby certify that all information is true and correct to the best of my knowledge and ability.

Please provide additional information to help us determine eligibility:

_____

_____

_____

_____

_____

_____

***NOTE: THIS PORTION MUST BE COMPLETED BY ONE OF THE FOLLOWING RECOGNIZED PROFESSIONALS: registered nurse, physician, social worker, psychologist, physical therapist, chiropractor, occupational therapist, speech pathologist, nurse practitioner, physician's assistant, mental health counselor, respiratory therapist, vocational rehabilitation counselor, or recreation therapist employed by a medical facility.**

Print Name and Title:

Signature _____ **Date** _____

Clinic/Agency _____ **Phone** _____

Address _____ **City** _____

Fax Number _____