



**DALLAS AREA RAPID TRANSIT
Paratransit Services
Physician Verification of Disability Form**

Date _____

Patient Name _____

DOB _____

*****PLEASE NOTE*****
This form must be filled out in its entirety. Any form with requested information omitted will not be processed and will be returned to patient.

The person named above is **currently being treated** or **was formerly treated** by me. The person has informed me of his/her intent to apply for **DALLAS AREA RAPID TRANSIT (DART) Paratransit Services**. The information provided in this form is intended to verify any medical/health conditions that **prevent** the applicant from using **DART**'s bus and rail services.

The following information confirms the patient's disability:

Diagnosis/Disability:

Date of Onset:

Disability Status (Select One):

Temporary: _____ months

Permanent

Primary Mobility Device(s):

DEVICE(S)	PRESCRIBED		REQUIRED FOR MOBILITY	
<input type="checkbox"/> MANUAL WC	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> EC/SCOOTER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> WALKER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> CANE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO

My signature below certifies that the above information is accurate.

*Physician Signature

License Number _____ State _____

Print Physician Name and Credentials (MD/DO)

Physician's Office Phone Number