



**DALLAS AREA RAPID TRANSIT  
Paratransit Services  
Physician Verification of Disability Form  
(For Visual Impairments)**

Date \_\_\_\_\_  
 Patient Name \_\_\_\_\_  
 DOB \_\_\_\_\_  
 Social Security \_\_\_\_\_

\*\*\*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 eye conditions/diseases that prevent the applicant from using **DART**'s bus and rail services.

**Name of Eye Disease/Condition:** \_\_\_\_\_ **Date of Onset:** \_\_\_\_\_

The following information confirms that the patient is legally blind in both eyes:  
**Visual Fields or Visual Acuity with best correction (must complete for both eyes):**

Right eye: \_\_\_\_\_ Left eye: \_\_\_\_\_ Both eyes: \_\_\_\_\_

**Prognosis:** \_\_\_\_\_

**Disability Status (Select One):**

- Patient will be visually impaired for \_\_\_\_\_ months.
- Patient's visual impairment is permanent.

My signature below certifies that the above information is accurate.

\_\_\_\_\_  
**\*\*Physician Signature and Credentials (M.D., O.D.)**

\_\_\_\_\_  
**Print Physician Name and Credentials (M.D., O.D.)**

License Number \_\_\_\_\_ State \_\_\_\_\_

\_\_\_\_\_  
**Physician's Office Phone Number**

I, \_\_\_\_\_ hereby verify that the diagnosis of disability listed above has been reviewed by me, is accurate and true, and represents the current visual impairment of the applicant named on this form.

**\*\*Must be signed by a licensed optometrist or ophthalmologist.**