Call-n-Ride

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Call-n-Ride Disability Certification Form

Applicants aged between **18-64** must provide proof of disability to participate in the Call-n-Ride Program. The Disability Certification Form **MUST** be completed by a Licensed Physician, PA or CNRP for Call-n-Ride participation.

PART A. TO BE COMPLETED BY APPLICANT			
Last Name:	First Name:		MI:
Address:	DOB:	Gender: ◯ Female ◯ Male	
City:	State:	Apt.	Zip:
I authorize the Call-n-Ride Representatives to contact my healthcare provider listed below to obtain any addition information related to my disability.			
Applicant Signature	Date		

PART B. TO BE COMPLETED BY PHYSICIAN OR OR CNRP			
The purpose of this form is to determine certification of disability for the applicant listed. Please provide verifiable disability information.			
Disability: ☐ Mental ☐ Physical ☐ Other: _____			
Diagnosis:			
Symptoms:			
Disability is: ◯ Permanent ◯ Short-term for a period of _____ months (must be six (6) months or more)			
If the disability is short-term what is the anticipated time of disability?			
Physician Name			
Professional License #	State		Expiration Date
Office Address		Telephone #	
City	State	Zip	
I certify and affirm that the applicant identified above has the disability stated above. I also certify and affirm that all information presented in this form is true and accurate. I make this certification and affirmation under penalty of perjury.			
Physician Signature	Date		

FOR OFFICE USE ONLY		
CNR #:	**Verified Date:**	**Staff:**