Call-n-Ride Program

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Call-n-Ride (CNR) Disability Certification Form

Applicants aged between **18-62** 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 CRNP for Call-n-Ride participation.

PART A. TO BE COMPLETED BY APPLICANT

Last Name:	First Name:	MI:
Address:	DOB:	Gender: ☐ Female ☐ Male
City: / State:	Zip:	Phone:

I authorize the Call-n-Ride Representatives to contact my healthcare provider listed below to obtain any addition information related to my disability.

Applicant's Signature:	Date:

PART B. TO BE COMPLETED BY PHYSICIAN, PA OR CRNP

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's Signature:	**Date:**

FOR OFFICE USE ONLY

CNR #:	**Verified Date:**	**Staff:**