SHELBY PUBLIC TRANSIT

APPLICATION FOR REDUCED FARE

Applicant (passenger) section to fill out

Name: ______________________________

Address: ______________________________

____

Birthday: ____________________

Phone No: (   ) ____________________ Cell No: (   ) ____________________

Driver's License number: ______________________________ OR

Other Documentation: ______________________________

Do you require any service needs for transport? (example: wheelchair lift) YES / NO

If yes explain: ______________________________

Emergency Contact: ______________________________

Relation: Phone Number: ______________________________

Passenger Signature: ______________________________ Date: ____________

****PHOTO ID REQUIRED TO COMPLETE FORM****

*****YOU WILL NOT BE SEEN WITHOUT AN APPOINTMENT*****

Doctor or licensed physician section to fill out

DISABILITY CERTIFICATION:

AS DEFINED IN THE ADA ACT OF 1990, CHAPTER 126, SECTION 12102

at least one box below must be maked

- ☐ Mobility
- ☐ Sensory
- ☐ Other

one of the two boxes below must be marked

- ☐ Permanent Disability (good for 3 years)
- ☐ Temporary Disability (date required-less then 3 years)

until date ____________________

DOCTOR'S SIGNATURE: ______________________________ DATE: ____________

OFFICE ONLY

DOCUMENTATION: Recipient of Disability Payment: (List source - SSDI)

____

Photo ID available: YES / NO

Approved by: ______________________________ Date: ____________

Card Number: ____________

Updated or Entered in software: date put on calendar: date date

EXPIRES