***** OFFICE USE ONLY *****

Received: _____

__/ Permanent

__/ Exp. Date _____

SunLine Transit Agency
Half-Fare Program

Physician Verification of Disability Form
(Deliver or mail to your doctor)

Doctor: Please complete, sign and mail this Verification of Disability form as soon as possible. Your patient is being considered for enrollment in SunLine's Half-Fare Program. The information provided in this form is intended to verify the disability of your patient allowing them half-fare on any SunLine fixed-route services.

Mail to: 32-505 Harry Oliver Trail, Thousand Palms, CA 92276, ATTN: Marketing Department
Or fax to: 1-760-343-2077

Patient Name _____

DOB _____ Date _____

SunLine has established the following instructions as being necessary for effective use of mass transit:

- Negotiating a flight of stairs
- Boarding or alighting from a standard bus
- Standing on a moving bus
- Reading information signs
- Hearing announcements by bus operators
- Pulling the cord to signal an operator to stop the bus

Please answer the following questions

Does this patient require a travel aide or attendant? ___/ Yes ___/ No

Disability Status (select one):

___/ Patient will be temporarily disabled for ____ months.

___/ Patient is considered permanently disabled.

For Visual Impairment

Visual Fields or Visual Acuity with best correction (must complete for both eyes):

Right eye: _____ Left eye: _____

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

***** IMPORTANT NOTICE *****
THIS FORM WILL NOT BE ACCEPTED UNLESS COMPLETED IN ITS ENTIRETY BY THE SIGNING PHYSICIAN.

** Must be signed by licensed physician.

Physician Verification Form rev 11-09