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

Received: _____

__/ Permanent

__/ Exp. Date _____

**SunLine Transit Agency**
Taxi Voucher 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 Taxi Voucher 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: Taxi Department*
*Or email to: SRA@sunline.org*

Please include current proof of age or disability and a color photo.

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