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___ / Exp. Date: _____

SunLine Transit Agency
Half-Fare Program

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

Doctor/Health Care Provider: Please complete, sign and mail the Verification of Disability Form to SunLine Transit Agency as soon as possible. Your patient has applied for enrollment in SunLine's Half-Fare Program. The information 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: Customer Service
*Or Fax to: **(760) 343-3845**. ATTN: Customer Service*

Patient Name: _____

DOB: _____ Date Form Completed: _____

SunLine has established the following skills and abilities as being necessary to effectively mass transit services:

- ❖ 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 the operator to stop the bus

Please answer the following questions:

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

Disability Status (Select one):

___/ Patient is/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 to true and accurate:

_____ _____

** Physician/Health Care Provider Signature/Credentials

Print Physician/Health Care Provider Name and Credentials

License Number: _____

State: _____

Office Phone Number: _____

***** IMPORTANT NOTICE *****
THIS FORM WILL NOT BE ACCEPTED UNLESS COMPLETED IN ITS ENTIRETY BY THE SIGNING PHYSICIAN OR HEALTH CARE PROVIDER

** Must be signed by licensed physician or other credentialed health care provider.