



**Department of Transportation/METRA
Reduced Fare Eligibility Certificate for Disable I. D.**

This form is for a Disable I D only. This I. D. enables residents of the METRA service area who are disabled in a way that affects their ability to travel, eligible for reduced bus fares. Listed below are the requirements on which individuals may be certified as a "Disabled Person". Please *circle* any of the following disabilities as they apply to your patient or client.

I certify that _____ who currently resides at _____
Columbus, Ga. 3190__, is a disabled person due to the following requirements.

1. Non-Ambulatory Disabilities: Impairments that, regardless of cause or manifestation, for all practical purposes confine individuals to wheelchairs.
Specify Specific Disability _____
2. Semi-Ambulatory Disabilities: Impairments that cause individuals to walk with difficulty or insecurity. Individuals using braces or crutches, amputees, and those with arthritic neuromuscular, pulmonary, or cardiac disorders may be semi-ambulatory.
Specify Specific Disability _____
3. Sight Disabilities: Total blindness or incorrect impairment affecting sight to the extent that the individual functioning in public areas in insecure or exposed to danger.
Specify Specific Disability _____
4. Hearing Disabilities: Total deafness or uncorrectable hearing handicaps that might make an individual insecure in public area because they are unable to communicate or hear warning signs.
Specify Specific Disability _____
5. Disabilities of Coordination: Faulty coordination palsy from brain, spinal, or perinea nerve injury.
Specify Specific Disability _____
6. Mental Disorder: Applicant is unable to perform routine repetitive tasks or has physical or other mental impairment resulting in restriction of function and cannot become licensed to operate a vehicle.
Specify Specific Disability _____
7. Brain Damage: Diagnosis by a psychiatrist, neurologist, or clinical pathologist establishing that the applicant has organic brain syndrome.
Specify Specific Disability _____
8. Other: Please Specify
Specify Specific Disability _____

The information contained on this eligibility certificate must be completed in full and you may be contacted for verification purposes.

Signature (Physician or Approved Agency)

Date (This form must be processed one week from this date).

Printed Name (Physician or Approved Agency)

Phone Number (Physician or Approved Agency)

Address (Physician or Approved Agency)

PLEASE READ THE FRONT AND BACK OF THIS FORM

