



DALLAS AREA RAPID TRANSIT
Paratransit Services
Physician Verification of Disability Form

\*\*\*PLEASE NOTE\*\*\*
This form must be filled out in its entirety. Any form with requested information omitted will not be processed and will be returned to patient.

Date
Patient Name
DOB
Social Security

The person named above is currently being treated or was formerly treated by me. The person has informed me of his/her intent to apply for DALLAS AREA RAPID TRANSIT (DART) Paratransit Services. The information provided in this form is intended to verify any medical/health conditions that prevent the applicant from using DART's bus and rail services.

The following information confirms the patient's disability:

Diagnosis/Disability: Date of Onset:
[Blank lines for input]

Prognosis:

Disability Status (Select One):

- Patient will be temporarily disabled for months.
Patient is considered permanently disabled.

My signature below certifies that the above information is accurate.

Physician Signature and Credentials (M.D., D.O.)

Print Physician Name and Credentials (M.D., D.O.)

License Number State

Physician's Office Phone Number

\* I, hereby verify that the diagnosis of disability listed above has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named on this form.

\*Must be signed by a licensed physician.