DALLAS AREA RAPID TRANSIT
Paratransit Services
Physician Verification of Disability Form

Date: _____

*****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.

Name: _____ DOB: __/___/___

The person named above 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 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:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Primary Mobility Device(s):	**PRESCRIBED**	
☐ Manual Wheelchair	◯ YES	◯ NO
☐ Powered Wheelchair	◯ YES	◯ NO
☐ Powered Scooter	◯ YES	◯ NO
☐ Walker w/o Seat	◯ YES	◯ NO
☐ Rolling Walker w/Seat or Basket	◯ YES	◯ NO
☐ Cane	◯ YES	◯ NO

My signature below certifies that the above information is accurate.

_____ **License Number _____State_____**
***Physician Signature**

_____ _____
Print Physician Name and Credentials (MD/DO/RN/PA/FNP) **Physician's Office Phone Number**