RE-APPLICATION

Section I, PART A Contact Information

To be completed by, or for, the applicant

Last Name:________________First Name:________________Middle Initial:_____

Home Address:____

__________________________________ ______________________________

(City) (ZipCode)

Home Phone:( ) ____________________ Business Phone:( ) ________________

Date of Birth:_______________________ Sex: ___Male ___Female

Photo ID Attached: ___ Yes

Section I, PART B Changes

Have there been any changes that may affect the conditions outlined in your original paratransit certification?: ____Yes ____No

If yes, please explain and attach updated Professional Verification from your physician.

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If no, please return this page only. There is no need to resubmit the Professional Verification.

____ _______________

Signature of Applicant Date

Section I, Part D Professional Verification
to be filled out by Health Care Professional

Dear Health Care Professional:

You are being asked by ____________________ to provide information
(applicant)
regarding their ability to use our transit system. Federal law requires that OSU-Stillwater Community Transit provide Paratransit services to persons who cannot use fixed-route transit services. The information you provide will allow us to evaluate this request and its application to specific trip requests. Certification to use this service will not be based solely on your verification in this document. Thank you for your cooperation in this matter.

To qualify for Paratransit services, a person must be unable to use regular public transit due to physical or cognitive disability. Individuals qualify if:

1. as the result of their disability, they cannot board, ride, or disembark a OSU-Stillwater Community Transit fixed route bus (all fixed route buses are lift-equipped); or
2. they have a specific impairment-related condition which prevents them from getting to/ from a bus stop.

PLEASE NOTE: This does not include persons who find it uncomfortable, inconvenient, or difficult to get to and from bus stops.

Resources for this program are limited and your evaluation of each person must be based solely upon the individual's ability to use regular transit. Your verification should consider only presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this program. Evaluation is based on federal guidelines are used for establishing paratransit accessibility. The determination will be applicable for use on any of the nation's ADA compliant paratransit services.

CERTIFICATION PROCESS

1. Applicant has completed Parts A through C.
2. Health Care Professional completing Part D must be guided by criteria explained herein.
3. OSU-Stillwater Community Transit or its authorized agents may contact the certifying health care professional to verify accuracy of the information.
4. OSU-Stillwater Community Transit's certification agent, the OSU Student Disability Services Office, will make the final determination of the applicant's eligibility.
5. The application must be filled out COMPLETELY for processing to occur.

OSU-Stillwater Community Transit is a limited special transportation service for disable persons who, because of cognitive or physical disability, find it IMPOSSIBLE to use reg public transportation. All parts must be completely filled out by the authorized person w signs below. Incomplete forms will be returned to the applicant.

A. Indicate nature of applicant's disability (check as many as may apply):

☐ Non-ambulatory (uses wheelchair for mobility)
☐ Impaired or assisted ambulatory requiring special mobility aid __________
☐ Arthritis/Osteoarthritis (specify extremity) ____________________
☐ Amputation (specify extremity) ____________________
☐ Cerebrovascular Accident
☐ Pulmonary Ills (does applicant require portable Oxygen Yes ☐ No ☐
☐ Neurological Impairment
☐ Cardiac Ills
☐ Kidney disease/dialysis
☐ Sight disability Legally blind ☐ Visually impaired ☐
☐ Incoordination
☐ Mental Retardation Moderate ☐ Severe ☐ Profound ☐
☐ Cerebral Palsy
☐ Autism
☐ Severe Muscle Spasms
☐ Seizures
☐ Loss of consciousness
☐ Mental illness (specify what it is about cognitive disability that limits use of regula bus service)
____
____

☐ Other ____________________
____

Describe type and severity of disability in detail and how it prevents use of transit: ____________________
____
____

B. The disability is: Permanent ☐ Temporary ☐
If temporary, expected duration is ____________________

In your opinion, must this individual bring a competent attendant on each trip?
Yes ☐ No ☐

If applicant is visually impaired or blind, developmentally disabled, suffers from neurological impairment or is mentally limited, has applicant ability to receive training in fixed route buses? Yes ☐ No ☐

How far can the applicant walk unassisted? (If applicant uses a wheelchair or other mobility device, how far can the applicant travel using that device?):

☐ 1 block
☐ 2 blocks
☐ 4 blocks (1/4 mi)
☐ No limitation
* Other ____________________

Is there any other effect of the disability of which OSU-Stillwater Community Transit should be aware? Please provide an explanation. ____________

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C. Is the applicant on any medication which might have an impact on ability to use public transportation ☐ Yes ☐ No Explain ____________

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____

D. Your professional area of specialization is:

☐ Family Physician
☐ Cardiologist
☐ Podiatrist
☐ Optometrist
☐Audiologist
☐ Psychologist
☐ Physical Therapist
☐ Rehabilitation Specialist
☐ Independent Living Specialist
☐ Registered Nurse/LPN
☐ Other ____________

HEALTH CARE PROFESSIONAL CONTACT INFORMATION

Name: ______________________________

Title: ______________ Agency/Company Name: ______________

Professional License # (if applicable): ______________

Office Address: ______________________________
(Street)

__________ __________ Office Phone Number: (   ) ______________
(City) (Zip)

I hereby certify that the above information is true. The OSU Student Disability Services office will make the final determination on the applicant's eligibility for OSU-Stillwater Community Paratransit service.

______________________ ______________
(Signature) (Date)

THANK YOU FOR YOUR ASSISTANCE IN PROCESSING THIS APPLICATION!