



REDUCED FARE PHOTO ID APPLICATION

Hernando County Transit Management
700 Aeriform Drive, Brooksville, FL 34601
(352) 754-4444
www.hernandobus.com

This application requires the physician verification form to be completed by your doctor. Once this application is completed, please present it the above address. (Large print and applications in other languages are available upon request)

APPLICANT INFORMATION

Name of Applicant _____ D.O.B. _____
Please Print

Physical Address of Applicant:

Address _____ City _____ State - Zip Code _____

Mailing Address: (If different than physical address)

Address _____ City _____ State - Zip Code _____

Phone number _____

I understand that the medical information requested is confidential and will not be shared with any other person or agency. I authorize the physician completing this application to release information about my disability to TheBus for the purpose of determining my eligibility for the Disabled Reduced-Fare Program. If approved, I will show my photo ID each time I board the bus and upon request, and understand that use of my ID by someone other than me is fraudulent and will result in the revocation of my Reduced-Fare Program privileges.

Applicant's signature _____ Today's date _____

<p>FOR OFFICE USE ONLY: Date application received at THE Bus _____ Comments: _____ _____ _____ Staff reviewing: _____ Date: _____</p>	<p>Results of this application: <input type="checkbox"/> Eligible Card # issued: _____ <input type="checkbox"/> Ineligible <input type="checkbox"/> Application Incomplete Returned On _____</p>
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Physician Verification Form

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Applicant Name _____

Under Federal Regulations 49 CFR, Parts 27 and 37 (or as subsequently amended) - Transportation for Individuals With Disabilities - Disabilities are those permanent or temporary physical or mental impairments that substantially limit one or more of the major life functions of such individual. These may include, but may not be limited to, vision or hearing impairment, mental retardation, motor skills impairment, heart or respiratory ailments.

Medical Certification - Please print or type

Physician Name _____ License #/ State _____

Office Address _____ Suite # _____

City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____

What is the applicant's diagnosis/disability?

Is the disability permanent? Yes No

If no, then for how long? _____

I hereby certify that the medical information provided above is true and correct, and I understand that false or fraudulent statements and certifications are punishable by law under Title 18 USC, Subsection 10001, (1982).

Signature of Physician _____ ***Date*** _____