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_____

FOR OFFICE USE ONLY:
Date application received at THE Bus_____
Comments: _____
_____
_____
Staff reviewing: _____ Date: _____

Results of this application:
☐ **Eligible**
Card # issued: _____
☐ **Ineligible**
☐ **Application Incomplete**
Returned On _____

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, intellectual disability, 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*** _____