



SAN JOAQUIN RTD
PO Box 201010
Stockton, CA 95201
(209) 948-5566

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize you to **release any information necessary to determine my eligibility** for ADA Paratransit service provided by the San Joaquin Regional Transit District (RTD).

RTD has assured me that the requested information will be held in strictest confidence, and will be used only to determine my eligibility for paratransit service.

Identification of Physician or Health Care Professional

(Please type or print clearly)

Name and Title of Professional _____

Address _____, _____, _____
(Number and Street) (City) (Zip Code)

Agency _____

Phone # _____ Fax # _____

Applicant Information

Date of Birth _____ SSN # (Last four) _____

Signature of Applicant _____ **Date** _____

Printed Name of Applicant _____

RTD PROFESSIONAL VERIFICATION FORM

To process this application, RTD needs information about the effects of the applicant's disability on his/her **functional capability** to ride the regular fixed route bus service. This information is necessary to determine whether he/she is eligible for paratransit service under the regulations of the Americans with Disabilities Act (ADA).

The information you provide in this form will aid RTD in making an ADA eligibility determination. For the benefit of the applicant, please answer the questions as fully and accurately as possible. All information will be kept confidential.

The individual's condition must **prevent** travel on a RTD fixed route, either all of the time, temporarily, or only under certain circumstances. Disability alone and distance to and from a bus stop do not, by themselves, qualify a person for paratransit service. **Inconvenience, decreased comfort, and/or pain are not a basis for qualification.**

(Please type or print clearly. Do NOT use ICD-9 or DSM codes.)

Applicant's Name _____

Capacity in which you know the applicant _____

Medical diagnosis _____

_____ Date of Onset _____

Prognosis _____

1. Does the applicant use any of the following aids for mobility?
(Check all that apply).

- | | |
|-------------------------|---------------------|
| Manual Wheelchair | Electric Wheelchair |
| Power Scooter | Cane |
| Crutches | Walker |
| Personal Care Attendant | Service Animal |
| Other _____ | None |

2. What category is the applicant's disability?

Visual Physical Mental Impairment

3. Applicant's Height _____ Weight _____

4. Is the applicant's condition temporary? ____Yes ____No
If Yes, expected duration: ____/ ____/ ____

