To be completed by the medical provider of AAR Applicant

Name/Credential of Professional:

License Number of Professional:

Phone Number:

Name of applicant:

How long has this applicant been under your care?

Most recent visit date:

Does the applicant's disability prevent the applicant from getting to / from and riding the bus / light rail system?

◯ Yes ◯ Sometimes ◯ No

If yes or sometimes, please explain how the applicant's disability or health related conditions <u>prevent</u> use of the public bus / light rail system:

Does this applicant need someone to accompany him/her at all times? ◯ Yes ◯ No

Does the applicant have the mental capacity, visual and/or hearing ability to:

Ask for, understand and follow directions? ◯ Yes ◯ No

Ask for assistance from appropriate sources? ◯ Yes ◯ No

Safely cross a major street? ◯ Yes ◯ No

Safely travel through crowded/complex facilities? ◯ Yes ◯ No

Recognize a destination or landmark? ◯ Yes ◯ No

Signal a bus operator to get off at destination stop? ◯ Yes ◯ No

Filter environmental noise? ◯ Yes ◯ No

Judge traffic flow? ◯ Yes ◯ No

Regarding vision impairments only:

Question		
Is the applicant able to locate steps or curbs?	○ Yes	○ No
Is the applicant impacted by bright sunlight?	○ Yes	○ No
Is the applicant limited by dimly lit conditions?	○ Yes	○ No
Is the applicant's vision impacted at night?	○ Yes	○ No

Is the applicant, while using their mobility aid, able to independently:

Question		
Travel outdoors on their property?	○ Yes	○ No
Travel up to 1 block?	○ Yes	○ No
Travel up to 3 blocks?	○ Yes	○ No
Stand for up to 15 minutes with support?	○ Yes	○ No
Stand for up to 15 minutes without support?	○ Yes	○ No
Travel up or down hills?	○ Yes	○ No

These impairments are:

○ Stable ○ Progressive ○ Degenerative ○ Temporary, duration: ____________

Does weather impact the applicant's ability to travel?

Condition				
Windy Weather			○ Yes	○ No
Cold weather	○ < 30 °F	○ < 40 °F	○ < 50 °F	○ No
Hot weather	○ > 70 °F	○ > 80 °F	○ > 90 °F	○ No

____________________________ ____________________________

Signature of Provider **Date**

*** MEDICAL VERIFICATION FORMS LACKING A SIGNATURE AND LICENSE NUMBER MAY NOT BE PROCESSED ***

Please return this form to the applicant, or fax to 303-299-2169, once completed.