SECTION A — TO BE COMPLETED BY THE APPLICANT

Last Name_____First Name_____Initial _____
Address_____City_____State_____Zip Code_____
Telephone_____E-Mail_____Date of Birth_____

I understand that the purpose of this certification form is to determine the eligibility for the reduced fare program and therefore agree to release the information below to CobbLinc for this purpose. I understand that the completed form will remain on file with the Carrier, but will not be made available to any other person or agency except those necessary to administer the reduced fare program.

Signature_____

SECTION B — TO BE COMPLETED BY THE HEALTH CARE PROVIDER

This is to certify that _____ meets the eligibility criteria of transportation
(Applicant's Name)

disabled and is_____ eligible for a reduced fare.
(permanently or temporarily)

If it is a temporary disability, how long is it expected to last? Month _____ Year _____

Is attendant care necessary for this person while traveling on public transportation?_____

How long have you known the applicant? Number of years_____

SECTION C — TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Certification has been approved: Yes_____ No_____

Please give a brief description of the disability_____

SECTION D — TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Signature_____Registration Number_____
Print or Type Name_____Date_____
Address_____City_____State_____Zip_____
Telephone_____E-Mail Address_____

CCT USE ONLY: APPROVED ☐ DENIED ☐ CARD NO. DATE