**APPLICATION FOR REDUCED FARE SERVICES**

**PART A: ALL APPLICANTS MUST COMPLETE THIS SECTION IN ITS ENTIRETY. PLEASE PRINT.**

1. **Last Name:**
2. **First Name:**
3. **Address:**
4. **City/State:**
5. **Zip Code:**
6. **Home Phone #:**
7. **Cell Phone #:**
8. **Date of Birth:**
9. **Emergency Contact Information:**
   - **Name:**
   - **Phone:**
10. **Would you like training to ride the bus?**
   - □ Yes
   - □ No
11. **If you use a device, what type?**
   - □ Scooter
   - □ Walker
   - □ Cane
   - □ Standard Wheelchair
   - □ Electric Wheelchair
   - □ Other: ____________________________
12. **Signature of Applicant:**
13. **Date:**

By submitting this application, you are giving consent to METRO to contact your medical professional or agency official to verify the information contained within this application.

**PART B: TO BE FILLED OUT BY MEDICAL PROFESSIONAL OR AGENCY OFFICIAL (PLEASE PRINT LEGIBLY).**

*APPLICATIONS WILL BE REJECTED IF ANY AREA OF PART B IS FILLED OUT BY APPLICANT.*

14. **Give a detailed description of disability/impairment:**
15. **Is this disability permanent?**
   - □ Yes
   - □ No
   - If no, what is the anticipated duration (in months)? ____________________________
16. **□ I recommend this individual for reduced fare service and is public transit appropriate**
   - □ I do not recommend this individual for service at this time

I, the undersigned medical professional, certify that my client named above is disabled, however, is able to use METRO fixed route/line service. By signing this, I agree to the validity of the information presented in this application. Please consider this application for Reduced Fare.

Printed Name: _______________________________________________________________________
License # or ID #: ____________________________ Agency: ________________________________
Address: ___________________________________________________________________________
City/State/Zip: _______________________________________________________________________
Phone: ____________________________ Fax: ____________________________
Signature: ____________________________ Date: ____________________________

Knowingly providing fraudulent information on this application may result in loss of current and/or future service.

**LARGER PRINT APPLICATION AVAILABLE UPON REQUEST**

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This application must be filled out completely to be considered for service. Incomplete applications will be returned to the applicant or medical professional. As a part of the application process, you may be required to participate in an assessment to determine your eligibility.

REV 11/16