MONTGOMERY AREA PARATRANSIT Phone (334)625-4691 Fax (334)625-4682

MEDICAL INFORMATION FORM

Medical Professional, (Doctor, RN, LPN, Social Worker, Case Worker) Please complete Section A - E as appropriate.

Applicants Name:_____

MAP Services are for persons who cannot use MATS fixed routes. The information you provide will allow appropriate evaluation of this request for certification. (Section A & E and at least one of section B-D must be completed. THANK YOU!

SECTION A.

1. Capacity in which you know the applicant:_____
2. What is the health condition or disability which prevents applicant from using regular bus service?_____
3. Is this public transportation disability temporary? Yes ❒ No ❒

SECTION B. If applicant has a visual impairment:

1. Visual Acuity with best Correction Right Eye ❒ Left Eye ❒ Both❒
2. Visual Fields Right Eye ❒ Left Eye ❒ Both❒
3. Visual Impairment Right Eye ❒ Left Eye ❒ Both❒

SECTION C. Does the applicant have mobility impairment? Is applicant able to:

1. Mobility Impairment Yes ❒ No ❒
2. Wait outside at street-side with no facilities (bench, etc) for 10 minutes? Yes ❒ No ❒
3. Using mobility aid or on their own how far is the applicant able to travel without assistance of another person?
   Less than 200 feet ❒ 1/4 mile (3 blocks) ❒ 1/2 mile (6 blocks) ❒
   3/4 mile (9 blocks) ❒ more than 3/4 mile ❒
4. Is the applicant's ability to independently travel this distance affected by : (check all that apply)
   Hot Weather ❒ Cold Weather ❒ Steep Hill ❒ None ❒
   Street Crossing ❒ Other ❒ Please explain_____

SECTION D: Does the applicant have a cognitive disability? Is applicant able to:

1. Cognitive Impairment Yes ❒ No ❒
2. Give address and telephone numbers upon request? Yes ❒ No ❒
3. Recognize a destination or landmark? Yes ❒ No ❒
4. Deal calmly with unexpected situations/changes in routine? Yes ❒ No ❒
5. Ask for, understand, and follow directions? Yes ❒ No ❒
6. Safely travel through crowed facilities (i.e. bus transfer center) Yes ❒ No ❒

SECTION E.

1. PROFESSIONAL'S NAME & TITLE:_____
2. FIRM:_____ TELEPHONE :_____
3. ADDRESS/CITY/ZIP:_____
4. SIGNATURE:_____