



**SAN JOAQUIN RTD**  
**PO Box 201010**  
**Stockton, CA 95201**  
**(209) 982-4514**

**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).

- |  |  |
|--|--|
| <input type="checkbox"/> Manual Wheelchair       | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Power Scooter           | <input type="checkbox"/> Cane                |
| <input type="checkbox"/> Crutches                | <input type="checkbox"/> Walker              |
| <input type="checkbox"/> Personal Care Attendant | <input type="checkbox"/> Service Animal      |
| <input type="checkbox"/> <b>Other</b> _____      | <input type="checkbox"/> 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: \_\_\_\_/ \_\_\_\_/ \_\_\_\_

5. Can the applicant wait outside without assistance for 15 minutes?

- Yes                       No

6. How far can the applicant travel with or without a mobility aid?

- Less than 1 block                                       Less than 3 blocks  
 Less than 6 blocks

7. Can the applicant cross the street without assistance?

- Yes                                       No

If No, why \_\_\_\_\_

8. Can the applicant comprehend written or spoken instructions?

- Yes                                       No

9. Can the applicant recognize a destination or landmark?

- Yes                                       No

**I hereby affirm under penalties of perjury that the statements made herein are true and correct.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please print your name and title: \_\_\_\_\_

License #: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

Agency: \_\_\_\_\_

**PLEASE MAIL COMPLETED FORM TO:**  
**San Joaquin RTD**  
**Attention: Accessible Services**  
**PO Box 201010**  
**Stockton, CA 95201**  
**ANY QUESTIONS, PLEASE CALL ACCESSIBLE SERVICES AT**  
**209-982-4514 Option #3**