



## Health Care Professional Verification

Access San Joaquin requires the information below to be fully completed in order to process DFC application.

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**Medical diagnosis** (do not use medical abbreviations):

Is the applicant's condition temporary?     Yes     No

If yes, how long? \_\_\_\_\_

**Mobility Aids (check all that apply):**

- |   |                                      |   |  |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> Cane           | <input type="checkbox"/> Crutches    | <input type="checkbox"/> Walker               | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> Service Animal | <input type="checkbox"/> Oxygen      | <input type="checkbox"/> Motorized Wheelchair |  |
| <input type="checkbox"/> Power Scooter  | <input type="checkbox"/> Other _____ |   |  |

**Name and Title of Professional:**

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**Health Care Professional Signature:**

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**Date:**

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