MT-301 (10-01)

in cooperation with the
Federal Transit Administration

APPLICATION
REDUCED TRANSIT FARE
IDENTIFICATION CARD
REDUCED TRANSIT FARE PROGRAM
FOR HANDICAPPED PERSONS

Card Number_____

Social Security No._____

PART I TO BE COMPLETED BY APPLICANT (Please print or type)

NAME OF APPLICANT: | DATE:

(Last) (First) (Initial)

ADDRESS:

(Street) (City) (State) (Zip Code)

_____Male
_____Female

(_____)_____ _____ _____
Home Telephone No. Birth Date Signature

PART 11- TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED AGENCY (Please print or type)

I certify that the above named individual qualifies for a disability Reduced Fare Transit Identification Card because: (please check as many reasons as are applicable -For further explanation please see reverse side).

_____(1) The person possesses a Medicare Card and is under 65 years of age.

_____(2) The person cannot negotiate a flight of stairs or escalator with ease, reasonable speed, and! or without aid from another person.

_____(3) The person cannot board or leave a transit vehicle with ease, reasonable speed, and/or without aid from another person.

_____(4) The person cannot stand without major support in a moving vehicle operating under normal acceleration and deceleration.

_____(5) Due to uncorrectable visual impairment the person cannot read transit vehicle identifications or identify transit stops.

_____(6) Due to uncorrectable hearing impairment, the person cannot hear verbal announcements or transit information through either direct personal or electronic communication.

_____(7) The individual needs (for valid medical reasons) the aid of a cane, crutches, or other mechanical device to assist him or her in moving about.

_____(8) Due to physical or mental conditions, the person cannot use public transit without the help of another person or special training.

The person's disability can generally be described as:

_____

_____

_____

_____1. The disability is permanent (will last longer than twelve months)

_____2. The disability is temporary and can be expected to last until _____/_____
Month Year

Due to the disability indicated above I hereby certify that the above named applicant is unable to utilize mass transit facilities and services as effectively as persons who are not so affected, and to the best of my knowledge the above information is true and correct.

_____
AUTHORIZED SIGNATURE Date

_____
Name of Agency or Physician

_____
(Street) (City) (State) (Zip Code) Telephone No.

When properly completed please return to participating transit agency.