
Applicant information

Name: _____ Phone: _____

Street Address: _____

City: _____ Age: _____

I hereby authorize _____ (Physician or agency) to release information necessary to complete this application. This application must be verified by an agency or a physician before it can be considered for issuance of a reduced fare pass.

Agency Verification

_____ is eligible for reduced transit fares. The limitation qualifying this person was based on the applicant's inability to perform one or more of the following functions necessary for the affective use of mass transportation facilities without significant difficulty.

- | | |
|--|--|
| <input type="radio"/> Board or Alight from a standard bus. | <input type="radio"/> Read information signs. |
| <input type="radio"/> Stand in a moving bus. | <input type="radio"/> Hearing announcements by driver. |

This limitation is: Permanent Temporary – Length of Disability _____

Signature of Agency Representative: _____

Title: _____ Name of Agency: _____

Doctor's Verification

_____ is eligible for reduced transit fares. The limitation qualifying this person was based on the applicant's inability to perform one or more of the following functions necessary for the affective use of mass transportation facilities without significant difficulty.

- | | |
|--|--|
| <input type="radio"/> Board or Alight from a standard bus. | <input type="radio"/> Read information signs. |
| <input type="radio"/> Stand in a moving bus. | <input type="radio"/> Hearing announcements by driver. |

This limitation is: Permanent Temporary – Length of Disability _____

Doctor's Signature: _____

Applicant must return application to the Shoreline Metro Customer Service Office at 828 Pennsylvania Ave.

-----OFFICE USE ONLY -----

Completed by: _____ Date: _____