



REDUCED FARE MEDICAL DETERMINATION FORM

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

This medical determination form must be completed by a medical professional who can verify that the applicant submitting this form has a disability that is either physical, mental, or visual that substantially limits one or more of their major life activities.

I certify that the applicant's disability(ies) criteria is/are (please circle)

- 1) Mobility Impairment includes persons with significant mobility impairment, wheelchair users as well as mobility aid users.
- 2) Physical Impairments can include respiratory, cardiac, dialysis, and neurological problems.
- 3) Visual impairments include legally blind individuals as well as individuals with visual acuity no better than 20/200 in best eye after correction.
- 4) Mental Impairments includes mental and emotional impairment as outlined by the American Psychiatric Association present for at least 3 months and expected to continue for at least 3 months past the application date.
- 5) Hearing Impairments include total deafness and persons who's hearing loss is 70dba or greater.
- 6) Special Education Student in a NY State elementary, junior, or senior high school (Certification letter on school letterhead)

Explain the criteria (s) you circled? _____

In my professional judgment the applicant's disability is:

Temporary How Long? _____ Permanent

This form must be stamped by a medical professional, signed, and fully completed.

Signature: _____ Date: _____

Name (please print) _____ Telephone _____

Address: _____

City/Zip: _____ License #: _____

Completed forms should be brought to one of CDTA's Half Fare issuing sites for your pictured ID card. ID Cards will not be issued for time periods of less than 3 months or more than 3 years.