

Access Medical Verification Form

To be completed by your licensed healthcare provider

**SECTION I – APPLICANT INFORMATION**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**SECTION II – PROFESSIONAL INFORMATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name Last Name Title (MD, NP, PA)

License/certification number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Agency Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical diagnosis of disability or impairment (Do not use codes):

Under the Americans with Disabilities Act (ADA), if a person has the functional capability to use Metro, the person is not eligible for Access service. Disability alone and distance to and from a bus stop, by itself, do not qualify a person for Access.

Please explain how the applicant’s disability or impairment substantially limits one or more major life activities impacting their ability to use Metro transportation. This question must be answered in detail or the application will not be considered:

**OVER**

MedVer2023

Is the applicant’s disability permanent? \_\_\_\_\_\_Yes \_\_\_\_No, anticipated return date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

**Does/Can the applicant:**

Give addresses and phone numbers? Yes No

Recognize a destination or landmark? Yes No

Walk 200 feet without assistance? Yes No

Walk more than one (1) city block? Yes No If yes, how many?\_\_\_\_\_\_\_\_\_

Sign his/her/their name? Yes No

Be left alone on a transit vehicle? Yes No

Require a personal care assistant? Yes No

History of getting lost/wandering off? Yes No If yes, how often?\_\_\_\_\_\_\_\_\_

Does the applicant require the use of a mobility device(s)? Please explain:

**SECTION III – CERTIFICATION INFORMATION**

THIS CERTIFICATION HAS BEEN COMPLETED BY A LICENSED MEDICAL PROFESSIONAL.

I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis of disability listed as been reviewed by me, is accurate and true, and represents the current physical and/or cognitive condition of the applicant named in this form.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

**Important**: Falsification of this document to obtain, aid, or facilitate another in obtaining Access service violates Ohio Revised Code section 2021.13 and United States Code Title 18, section 1001. Penalties include fines up to $5,000 and imprisonment up to ten years.

MedVer2023