
PARATRANSIT CERTIFICATION OF DISABILITY

Fax this completed form and any supporting documents to 979.862.4817 or mail to Paratransit Coordinator, Texas A&M University, MS 1250, College Station, TX 77843.

I, _____ (Name of Physician), certify
_____(Name of Patient), to be a severely disabled person who
has been a patient of mine since ____/____/____ (date) and whose diagnosis is:

Please describe the physical and/or cognitive condition and how it functionally prevents the applicant from using the Texas A&M University bus service.

I also certify that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the application's medical diagnosis.

Signed this _____ day of _____, 200__

Signature of Physician

Medical License Number

Street Address

City State Zip Code