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Date: [Date]

To: [Transit Agency Name]
ADA Certification Department
[Transit Agency Address]
[City, State, Zip Code]

Subject: Medical Certification for ADA Paratransit Eligibility

Dear Paratransit Coordinator,

I am writing to certify the medical necessity of Paratransit services for my patient, **[Patient Full Name]**, born on **[Patient Date of Birth]**.

Diagnosis and Condition:

The applicant has been diagnosed with the following condition(s): [List Diagnosis]. This condition is [Permanent / Temporary until Date].

Functional Limitations:

Due to their medical condition, the applicant is prevented from using fixed-route public transportation because:

- [Reason 1: e.g., Inability to walk 200 feet without assistance]
- [Reason 2: e.g., Severe cognitive impairment affecting navigation]
- [Reason 3: e.g., Sensitivity to extreme weather or temperatures]

Mobility Aids:

The applicant utilizes the following at all times: [e.g., Manual Wheelchair, Power Scooter, Walker, Service Animal, or Oxygen Tank].

Professional Recommendation:

Based on my clinical evaluation, it is my professional opinion that [Patient Name] requires door-to-door or curb-to-curb Paratransit services to access essential activities and medical appointments.

Should you require further medical documentation or clarification, please contact my office at [Phone Number].

Sincerely,

[Signature]
[Physician Name, Title/Credential]
[Medical License Number]

[Clinic/Hospital Name]
[Clinic Address]