Date: [Date]

To: [Paratransit Agency Name]
Department: Eligibility Certification Department
Address: [Agency Address]

Subject: Medical Certification for Temporary Paratransit Services

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

I am writing to certify that my patient, [Patient Name], has a temporary medical condition that limits their ability to use standard fixed-route public transportation independently.

Diagnosis/Condition: [Brief Description of Condition]

Functional Limitations:
Due to this condition, the patient is currently unable to: [e.g., walk more than 200 feet, stand for long periods, or navigate transit transfers] safely or reliably.

Expected Duration:
The patient's need for paratransit services is temporary. We estimate these services will be required from [Start Date] until approximately [End Date].

Based on these functional limitations, I recommend that [Patient Name] be granted temporary eligibility for paratransit services to ensure access to essential medical appointments and daily activities.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
Medical License #: [License Number]
Clinic/Hospital Name: [Name of Facility]
Phone: [Phone Number]