Date: [Insert Date]

To: [Transit Authority Name]
Department: Paratransit Eligibility Department
Address: [Insert Address]

Subject: Medical Certification of Permanent Mobility Impairment

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Patient ID/Account Number (if applicable): [Insert ID]

To Whom It May Concern,

I am writing to formally certify that the above-named patient is under my professional care and has been diagnosed with a permanent mobility impairment. Due to this condition, the patient is unable to independently utilize standard fixed-route public transportation services.

Clinical Diagnosis: [Insert Diagnosis]

Functional Limitations:
The patient's condition results in the following permanent limitations regarding public transit use:

- Inability to walk or travel [Insert Distance, e.g., 200 feet] without significant assistance or a mobility device.
- Inability to stand for extended periods while waiting for a bus or train.
- Inability to navigate complex transit stations, stairs, or uneven terrain.
- [Optional: Insert other specific functional limitations].

Mobility Aids Used: [e.g., Manual Wheelchair, Power Chair, Walker, Crutches]

Duration of Impairment:
This condition is **permanent**. No improvement in the patient's functional ability to use fixed-route transit is expected in the future.

Based on these medical findings, I strongly recommend that the patient be granted permanent eligibility for paratransit services. If you require further medical documentation or clarification, please contact my office at [Insert Phone Number].

Sincerely,

Signature: ____________________________

Physician Name: [Print Name]
Medical License Number: [Insert Number]

Medical Practice/Clinic: [Insert Practice Name]
Phone: [Insert Phone Number]
Email: [Insert Email Address]