

Date: [Date]

To: [Paratransit Service Name] Eligibility Department

Address: [Service Address]

City, State, Zip: [City, State, Zip]

Subject: Medical Certification for Paratransit Eligibility

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

To Whom It May Concern,

I am writing to certify that the above-named patient is under my care for a visual impairment that significantly impacts their ability to use standard fixed-route public transportation independently.

Diagnosis: [Specific Diagnosis, e.g., Legal Blindness, Glaucoma, Macular Degeneration]

Visual Acuity/Field:

Right Eye (OD): [Measurement]

Left Eye (OS): [Measurement]

Visual Field: [Degree of peripheral vision]

Functional Limitations:

Due to this impairment, the patient experiences the following challenges (check all that apply):

- Inability to navigate complex intersections or cross busy streets safely.
- Inability to see or read bus headsigns, route numbers, or printed schedules.
- Difficulty navigating in low-light, nighttime, or bright-glare conditions.
- Difficulty locating bus stops or train platforms in unfamiliar areas.

Duration:

The patient's condition is: Permanent Temporary until [Date]

Based on these medical findings, I recommend that [Patient Name] be granted eligibility for paratransit services. This service is necessary for the patient to travel safely within the community.

If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Print Name]

Medical License Number: [Number]

Practice Name: [Clinic/Hospital Name]

Phone: [Phone Number]