Date: [Date]

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

Subject: Medical Certification for Paratransit Services

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

To the Eligibility Coordinator,

I am writing to certify that [Patient Name] is under my care for a cognitive disability that limits their ability to use the fixed-route public transportation system independently.

Diagnosis: [Specific Diagnosis, e.g., Intellectual Disability, Autism Spectrum Disorder, Dementia, or Traumatic Brain Injury]

Functional Limitations:
Due to this cognitive impairment, the applicant experiences the following barriers to using standard bus or rail services (check all that apply):

- Inability to navigate complex routes or remember destinations.
- Difficulty processing sensory information or managing crowds safely.
- Inability to understand or follow transit schedules and directions.
- Impaired judgment regarding traffic safety or interactions with strangers.
- Disorientation or wandering in unfamiliar environments.

Duration of Condition: [Permanent / Temporary until Date]

Professional Recommendation:
It is my professional opinion that [Patient Name] requires door-to-door or curb-to-curb paratransit services. They are unable to perform the functional tasks necessary to complete trips via the fixed-route system without significant risk to their safety or wellbeing.

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

Sincerely,

[Physician/Professional Signature]

[Printed Name and Title]
[Medical License Number]
[Facility Name]

[Phone Number]
[Email Address]