Date: [Date]

To: [Transit Authority Name]
Department: Paratransit Eligibility Department
Address: [Street Address, City, State, Zip Code]

Subject: Medical Certification for Personal Care Attendant (PCA) Requirement

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

To Whom It May Concern,

I am writing in my professional capacity as the [Physician/Healthcare Provider Title] for [Patient Name]. I have been treating this patient since [Date] for [Mention general nature of disability/condition].

Due to the patient's functional limitations, I am certifying that they require a Personal Care Attendant (PCA) to accompany them whenever they utilize paratransit services. The requirement for a PCA is based on the following medical necessity:

- [Example: Assistance with mobility and transfers]
- [Example: Support for cognitive or orientation impairments]
- [Example: Management of medical equipment or emergency medication]
- [Example: Personal safety and behavioral monitoring]

A PCA is essential for the patient to travel safely and effectively within the transit system. This requirement is [Permanent / Temporary until Date].

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

Sincerely,

Signature: ___________________________

Printed Name: [Provider Name]
Medical License #: [License Number]
Clinic/Facility Name: [Facility Name]
Phone Number: [Phone Number]