

[Date]

[Transit Agency Name]
[Paratransit Eligibility Department]
[Street Address]
[City, State, Zip Code]

RE: Medical Certification for Temporary Paratransit Services

To the Eligibility Coordinator,

I am writing to certify the medical necessity of temporary paratransit services for my patient, [Patient Name], born on [Date of Birth].

The patient underwent [Type of Surgery] on [Date of Surgery]. Due to the nature of this procedure, the patient is currently experiencing the following functional limitations: [e.g., inability to walk more than 50 feet, inability to climb stairs, weight-bearing restrictions, or use of a mobility device].

Because of these physical limitations, the patient is unable to access or navigate the standard fixed-route public transportation system at this time. Access to door-to-door or curb-to-curb paratransit service is required for the patient to attend follow-up medical appointments and complete essential daily activities during their recovery.

I anticipate these limitations to be temporary. I am requesting eligibility for paratransit services for a period of [Number of Months/Weeks], beginning [Start Date] and ending approximately [Estimated End Date].

Please contact my office at [Phone Number] if you require additional medical documentation or clarification.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Medical License Number]
[Practice/Clinic Name]
[Office Address]