Date: [Date]

To: [Paratransit Agency Name]
Address: [Agency Address]
City, State, Zip: [City, State, Zip]

Subject: Medical Certification for Paratransit Eligibility

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

To Whom It May Concern,

I am the primary healthcare provider for [Patient Name]. This letter serves to certify the patient's medical necessity for paratransit services due to a diagnosed cardiopulmonary condition.

Diagnosis: [Specific Condition, e.g., COPD, Congestive Heart Failure, Severe Asthma]

Functional Limitations:
Due to this condition, the patient experiences the following limitations regarding public transportation:

- Severe shortness of breath (dyspnea) when walking distances exceeding [Number] feet.
- Requirement of supplemental oxygen during travel.
- Exercise intolerance and fatigue that prevents standing for extended periods at bus stops.
- Inability to navigate stairs or steep inclines to access standard transit vehicles.
- Increased risk of cardiac or respiratory distress when exposed to extreme weather temperatures (heat/cold).

Certification:
Because of these functional deficits, it is my professional opinion that [Patient Name] is unable to utilize fixed-route public transportation independently. This condition is [Permanent / Temporary until Date].

Please grant [Patient Name] eligibility for paratransit services to ensure safe access to medical appointments and essential community activities.

Sincerely,

[Physician Signature]
Name: [Physician Name, MD/DO]
Medical License #: [License Number]
Phone: [Phone Number]
Clinic Name: [Clinic/Hospital Name]