

Date: [Date]

To: [Paratransit Service Provider Name]

Eligibility Department

[Provider Address]

[City, State, Zip Code]

RE: Medical Certification for Paratransit Services

Applicant Name: [Patient Full Name]

Date of Birth: [Patient DOB]

To Whom It May Concern,

I am the treating physician for [Patient Name], who has been diagnosed with the following neurological disorder(s): [Specific Diagnosis, e.g., Multiple Sclerosis, Parkinson's Disease, Epilepsy, Traumatic Brain Injury].

Due to this condition, the patient experiences the following functional limitations that impact their ability to use standard fixed-route public transportation:

- [Example: Impaired mobility and balance requiring use of a walker/wheelchair]
- [Example: Cognitive impairments affecting navigational skills and safety]
- [Example: Unpredictable seizure activity]
- [Example: Severe fatigue or sensory processing issues]

Based on my professional medical evaluation, these limitations prevent the patient from: [e.g., walking 200 yards to a bus stop, standing for long periods, or transferring between vehicles independently].

Therefore, I certify that [Patient Name] requires paratransit services for all trips or under the following conditions: [Specify conditions]. This requirement is [Permanent / Temporary until Date].

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical License Number]

[Clinic/Hospital Name]

[Phone Number]