Date: [Date]

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

Subject: Medical Certification for Door-to-Door Paratransit Assistance

To Whom It May Concern,

I am writing to formally certify the medical necessity for **[Patient Full Name]** (DOB: [Date of Birth]) to receive "Door-to-Door" paratransit assistance rather than "Curb-to-Curb" service.

The patient has been diagnosed with the following condition(s):
[List Medical Diagnosis/Disabilities]

Due to these functional limitations, the patient is unable to safely navigate the distance between their residence/destination and the vehicle curb independently. Specific challenges include:

- [e.g., Severe visual impairment requiring guided boarding]
- [e.g., Cognitive impairment causing disorientation or safety risks if left unattended]
- [e.g., Mobility limitations requiring physical assistance with thresholds or ramps]
- [e.g., Use of heavy medical equipment that requires driver assistance]

Therefore, it is my professional medical opinion that this patient requires the driver to meet them at the outermost door of their origin and escort them to the outermost door of their destination to ensure safe transport.

This requirement is: [ ] Permanent / [ ] Temporary until [Date].

If you require further clinical documentation or have questions regarding this certification, please contact my office at [Phone Number].

Sincerely,

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