Green Bay METRO

Green Bay Metro
901 University Avenue
Green Bay, WI 54302-1013

REQUEST FOR PROFESSIONAL VERIFICATION

This form must be completed by a licensed medical professional

Dear

The attached authorization form has been submitted by_____, who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. Federal law requires that Green Bay Metro provide paratransit services to persons who cannot utilize available accessible fixed route (bus) services. Please keep in mind that any condition which makes traveling to or from a boarding/disembarking location, or riding on a fixed route system more difficult or less comfortable, are not reasons for paratransit eligibility. The information you provide will allow us to make an appropriate evaluation of the request and its application to specific trip requests. Thank you for your cooperation in this matter.

Capacity in which you know the applicant: _____

_____

Medical Diagnosis of condition causing disability: _____

_____

Is the condition temporary? ☐ No ☐ Yes ☐ Expected duration until ___/___/_____

How does this condition affect the individual's ability to use accessible Green Bay Metro fixed route (bus) service?

_____

_____

_____

If provided with appropriate training and practice, would this person be able to use Green Bay Metro bus service?
☐ Yes ☐ No ☐ Sometimes (explain) _____

If the person has a disability effecting mobility,is the person able to:

Travel 200 feet without assistance of another person?
☐ Yes ☐ No ☐ Sometimes (explain) _____

Travel one half block without the assistance of another person?
☐ Yes ☐ No ☐ Sometimes (explain) _____

Travel 1/4mile without the assistance of another person?
☐ Yes ☐ No ☐ Sometimes (explain) _____

Travel 3/4 mile without the assistance of another person?
☐ Yes ☐ No ☐ Sometimes (explain) _____

Climb 12-inch steps without assistance?
☐ Yes ☐ No ☐ Sometimes (explain) _____

If "yes," how many in succession? _____

Wait outside without support for 10 minutes?
☐ Yes ☐ No ☐ Sometimes (explain) _____

Does this person use any mobility aids? If so, what? _____

Is this person able to negotiate ice/snow during travel?
☐ Yes ☐ No ☐ Sometimes (explain) _____

Is this person able to travel in extreme hot/cold weather?
☐ Yes ☐ No ☐ Sometimes (explain) _____

If the person has a visual impairment:

Visual acuity with best correction: Right eye ____ Left eye ____ Both eyes ____

Visual fields: Right eye ____ Left eye ____ Both eyes ____

If the person has a cognitive disability:

Is the person able to do the following:

Give address and telephone numbers upon request?
☐ Yes ☐ No

☐ Yes ☐ No

Deal with unexpected situations or changes in routine?
☐ Yes ☐ No

Ask for, understand, and follow directions?
☐ Yes ☐ No

Safely and effectively travel through crowded and/or complex facilities?
☐ Yes ☐ No

Is there any other effect of the disability of which Green Bay Metro should be aware? If so, please describe. (If necessary, continue on separate sheet). _____

_____

Your Name _____

Office Address _____

Office Telephone Number _____

Wisconsin Medical License Number _____

Signature _____ Date _____

This application must be fully completed. For information about ADA eligibility and the certification process, contact Green Bay Metro at 448.3450.

Return completed applications to: **Disabled Transportation Coordinator**
Green Bay Metro
901 University Avenue
Green Bay, WI 54302-1013