RIDERSHIP 18-59 YEARS OF AGE WITH DISABILITIES

ID#_____ TRIP: YES__NO__.

NAME_____BIRTHDATE_____.

ADDRESS_____PHONE_____.

CITY/ZIP_____CELL_____.

E-Mail Address: _____.

EMERGENCY CONTACT:

NAME_____RELATIONSHIP_____

HOME PHONE_____CELL_____WORK _____

DOCUMENTATION of AGE AND/OR DISABILITY_____
(For Office Use)

APPLICANT'S SIGNATURE:_____DATE_____

Describe the disability/condition, and indicate the impairment(s), aid(s) used, if applicable:

_____

_____

PHYSICIAN INFORMATION:

I hereby certify that the physical condition of the handicapped person listed herewith constitutes him or her as a handicapped person as described under par. 1-159.1 of the Illinois Revised Statues.

_____
(Physician's signature)

_____
(Physician's license number)

PLEASE PRINT OR TYPE BELOW:
Physician's Name_____

Address_____

_____

Telephone Number_____