

**LEE COUNTY TRANSIT AGENCY (LETA)
Paratransit Transportation Program
October 2005**

Physician's Certification Form

Patient's Information:

**IMPORTANT: Be sure the address you list below
is your legal physical address!**

Mail to:

Name: _____

Address: _____

Telephone No: _____

Lee-Russell Council of Governments
2207 Gateway Drive
Opelika, AL. 36801
(334) 749-9092
FAX: 334-749-6582

Source of Disability/Handicap (Check all that apply to the patient)

___ Amputation

___ Paraplegia

___ Quadriplegia

___ Legally Blind

___ Other Visual Impairment

___ Deaf

___ Arthritis/Orthopedic

___ Cerebral Palsy

___ Multiple Sclerosis

___ Stroke

___ Kidney Dialysis

___ Muscular Dystrophy

___ Epilepsy

___ Spina Bifida

___ Heart/Cardiac Condition

___ Emotional Problem

___ Mild Mental Retardation

___ Moderate Mental Retardation

___ Severe Mental Retardation

___ Schizophrenia

___ Alcoholism/Drug Addiction

___ Obesity

___ Pregnancy

___ Other _____

Is this condition:

___ Permanent

___ Acute (Temporary disability of more than three months duration)

___ Acute (Temporary disability of less than three months duration)

****** REMEMBER TO FILL OUT ALL INFORMATION ON EACH PAGE ******

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Aids Used:

- | | |
|--|---|
| <input type="checkbox"/> Wheelchair (Manual) | <input type="checkbox"/> Arm Brace |
| <input type="checkbox"/> Wheelchair (Power) | <input type="checkbox"/> Leg Brace |
| <input type="checkbox"/> Wheelchair (Amigo) | <input type="checkbox"/> Trunk Braces |
| <input type="checkbox"/> Artificial Lower Limb | <input type="checkbox"/> Cane (Walking) |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Cane (White) |
| <input type="checkbox"/> Crutches | |

Mobility Limitations:

(Check if your patient has severe difficulty)

- Walking one block
- Walking up and down stairs
- Sitting and getting up unassisted
- Standing for 10 minutes
- Reaching a handle and grasping it

CERTIFICATION:

I CERTIFY THE ABOVE INFORMATION TO BE AN ACCURATE MEDICAL ASSESSMENT OF THE DISABILITIES OF MY PATIENT _____
_____. I FURTHER CERTIFY THAT BECAUSE OF THESE
DISABILITIES THIS PATIENT IS UNABLE TO EFFECTIVELY UTILIZE FIXED ROUTE
TRANSIT VEHICLES.

Physician's Name: _____
(PLEASE PRINT)

Date: _____

Physician's Signature: _____

License Number: _____

Telephone: _____

Physician's Address: _____

******PLEASE FILL OUT ALL INFORMATION PROPERLY SO THAT THIS FORM CAN BE PROCESSED.
WE NEED ALL INFORMATION ON THE PATIENT AND THE PHYSICIAN******