PHENIX CITY EXPRESS (PEX)
Paratransit Transportation Program

Physician's Certification Form

Patient's Information:
IMPORTANT: Be sure the address you list below is your legal physical address!

Name: ________________________________

Address: ______________________________

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Telephone No: _________________________

Mail to:

Lee-Russell Council of Governments
2207 Gateway Drive
Opelika, AL. 36801
1-887-743-3739 (1-877-Ride Pex)
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:

____ Wheelchair (Manual)

____ Wheelchair (Power)

____ Wheelchair (Amigo)

____ Artificial Lower Limb

____ Walker

____ Crutches

____ Arm Brace

____ Leg Brace

____ Trunk Braces

____ Cane (Walking)

____ Cane (White)

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: _____________________________ Date: _____________
(PLEASE PRINT)

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******