**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: _____

_____

Telephone No: _____

**Mail to:**

Lee-Russell Council of Governments
2207 Gateway Drive
Opelika, AL. 36801
1-877-743-3739 (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******