

American Red Cross Lakeland Chapter– Transportation Services
2131 Deckner Av
Green Bay, WI 54302
(920) 227-4272 phone
(920) 227-4278 fax

Physician Certification Form

Attached is the new eligibility application for American Red Cross Transportation Services. Any individual under the age of 60 must complete/have physician complete necessary paperwork in detail and return those forms to our office for approval/denial. Any/All incomplete applications will be returned. This application and verification of the facts will be reviewed in office, within 10 business days of receipt each client will receive either a Denial/Approval letter of eligibility. We reserve the right to contact a client within those 10 business days, if further information is needed to make a decision. Any person denied service will receive appeal information, this will be included in denial letter.

Returned forms can be mailed to:

**American Red Cross
Attention: Transportation Services
2131 Deckner Av
Green Bay, WI 54302**

Or can be faxed to: (920) 227-4278

The information obtained in this certification form will only be used by American Red Cross Transportation Services for the provision of transportation services. The information will not be provided to any other person or agency.

This section must be filled out completely by the client

1. _____
Last Name First Name Middle Initial

2. Male: _____ Female: _____

3. _____
Home address Apt #

City State Zip code

4. _____
Home phone Other number

5. _____ / _____ / _____
Date of birth Age

6. What is the disability that prevents you from using City Transit/Buses? _____

7. Which of the following mobility devices do you use:
_____ Manual Wheelchair _____ Electric Wheelchair
_____ Powered scooter _____ Walker
_____ Crutches _____ Cane

8. If using wheelchair or scooter, does the total weight exceed 600 pounds?
_____ Yes _____ No

9. If you use a wheelchair/scooter, please list measurements:
_____ Length in inches
_____ Width in inches

10. If using a power scooter, is it equipped with brackets so that we may properly attach the belts/hooks for our 4 point tie down system?
_____ Yes _____ No

11. Do you require an aide/assistant to ride with you?
_____ Yes _____ No

12. What means of transportation do you use now?
Drive myself _____ Someone drives me _____
City Transit _____ Taxi _____
Other _____ - please explain _____

Any client who falsifies information will be automatically denied use of the service.

This physician certification form has been submitted by:

(Client Print Name here)

I hereby authorize the health care professional completing this form to release information about my disability. The information provided will allow us to make a decision on whether or not the above listed client will qualify for our door to door transportation service.

(Client please sign & date form here)

**This section must be completed by a licensed
medical professional**

Medical Professionals Name: _____

Address: _____ Phone: _____

(Please print)

Medical Diagnosis causing disability: _____

(Please print)

How does this disability SUBSTANTIALLY LIMIT him/her? (Check all that apply)

_____ care for self _____ walking _____ Performing manual tasks

_____ seeing _____ hearing _____ speaking

_____ breathing _____ working _____ Cognitive (learning)

Please explain how it limits him/her? (Be specific) _____

(Please print)

Is this condition temporary? Yes _____ No _____

If not, please list duration, until: _____

Is the individual able to use City Transit? Yes _____ No _____

If not, please explain why? _____

(Please print)

How far can the client travel without assistance? _____

Can the client climb steps? Yes _____ No _____

If yes, how many consecutive steps can they climb? _____

Physician Signature: _____ Date: _____