Application for Temporary Paratransit Eligibility

Date: _____ Date of Birth: _____

Name: _____ Email: _____

Home Phone Number: _____ Mobile Phone Number: _____

Mailing Address: _____

1. I am requesting Temporary Paratransit Eligibility Certification because:

2. I currently use, or will need to use, the following mobility aid(s) to assist me:

- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ Prosthesis
- ☐ Portable oxygen or respirator
- ☐ Manual wheelchair
- ☐ Motorized wheelchair or scooter
- ☐ Wheelchair 24 to 34 inches wide
- ☐ Personal Care Attendant
- ☐ Service Animal
- ☐ Not Applicable
- ☐ Other Answer:

3. Applicant Signature: _____

Treating Physician Certification

Length of Treatment / Recovery: _____

Treating Physician's Name: _____

NYS Certification Number or License Number: _____

I certify (1) the requested reason for Temporary Eligibility, and (2) that the applicant is unable to utilize RTS fixed route bus services during the recovery period due to this temporary disability.

Treating Physician's Signature: _____ Date: _____

Please mail the completed form to: RTS Access, 1372 E. Main St. Rochester, NY 14609
Or please email the completed form to: **access@myrts.com**