Application for Alternative Wheeled Mobility Devices

Lake County Transit Division
P.O. Box 7800, Tavares, Florida 32778
Phone: 352-323-5733 Email: abradford@lakecountyfl.gov
Hours: Monday-Friday 8:00 a.m.-5:00 p.m.

To use an alternative wheeled mobility device, a person must complete this application and submit the required medical certification, have the device evaluated by Lake County's ADA/TD Program Specialist.

Applicant Information (PLEASE PRINT LEGIBLY)

Name: ....
First name Last name

Mailing Address: ....

Phone #: ..... **Date of Birth:** .....

Certification of Eligibility section

I certify that I am a person with a disability who uses an alternative wheeled device for mobility.

To qualify to use an alternative wheeled mobility device, you must have the "Health Care Provider's Opinion and Certification" form completed and returned in a sealed envelope from the health care provider's office.

I agree to release the information I am sending to Lake County Transit Division for the purpose of making this application to use an alternative wheeled mobility device. I certify that the information I provide concerning my application is true and correct. I understand that Lake County Transit Division reserves the right to require proof of disability in addition to this form.

Signature of Applicant .....Date .....

Health Care Provider's Opinion and Certification

For individuals with permanent or temporary disabilities

Patient/Applicant Release

I authorize Dr. .....to verify my disability if requested to do so by Lake County Transit Division.

(Name of Licensed Health care provider)*

Patient / Applicant Signature .....Date .....

To be completed by physician or attach benefit information letter

Physician's name:.....

Physician's license number: .....

License issued date:.....

Mailing address:.....

Phone number: .....

I, ... hereby certify that I have examined the patient listed

(Name of Licensed Health care provider)*

above and it is my opinion that he/she is:

☐ Not disabled

☐ Disabled

It is my opinion that he/she ☐ **does** ☐ **does not** use an alternative wheeled device for mobility.

☐ Disability is permanent

☐ Temporary

If temporary, what is the duration of this disability?.....

.....

I certify that the above is correct and that I am legally licensed under the laws of the State of Oregon to practice medicine.

Physician signature.....Date.....

Please retain a copy of this form in your files. Customer service staff may contact you for verification. Completed application and Health Care Provider's Opinion and Certification may be mailed, faxed or hand-delivered by applicant ***in a sealed envelope*** *from the physician's office to the P.O. Box 7800, Tavares, Florida 32778 Fax: 352-323-5755. Phone: 352-323-5733.*