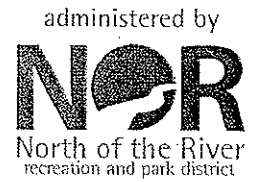




when you need us
We'll be there!



CONSOLIDATED TRANSPORTATION SERVICES AGENCY PHYSICIANS REPORT

TO BE FILLED OUT BY PHYSICIAN

Patients Name: _____

DOB: _____ Gender: M F

CIRCLE ONE

Is patient's condition permanent	YES _____	NO _____
Does patient require door to door assistance	YES _____	NO _____
Is patient ambulatory	YES _____	NO _____
Can patient climb up three 12 inch steps	YES _____	NO _____
Does patient use a wheelchair	YES _____	NO _____
Does patient require a caregiver	YES _____	NO _____
Can patient access the " GET BUS " fixed route system	YES _____	NO _____

Briefly explain patient's permanent disability and why it prevents them from using the fixed route bus:

Dr. Signature: _____ Date: _____