BATTLE CREEK TRANSIT
APPLICANT AUTHORIZATION FOR HEALTH CARE PROVIDER
RELEASE OF INFORMATION

Dear Applicant:

In order for Battle Creek Transit to evaluate your request for paratransit service eligibility certification, it may be necessary to contact a health care professional for additional information about your disability and the ability to use the regular fixed-route bus service. It is important that you identify a professional who is familiar not only with your disability, but who also understands your ability or inability to travel on the accessible fixed route system.

PLEASE COMPLETE AND SIGN THE FOLLOWING AUTHORIZATION, AND RETURN IT WITH YOUR COMPLETED APPLICATION FORM.

Health Care Professional information:

Name of Professional: (**PLEASE PRINT**) _____
Health Organization: _____
Address: _____
City/State/Zip: _____
Phone Number: Area Code ( ) _____

Please check the health care profession of the above-noted individual:

_____Physician
_____Registered Nurse
_____Rehabilitation Specialist
_____Occupational Specialist
_____Independent Living Counselor
_____Social Worker
_____Speech Pathologist
_____Audiologist
_____Psychologist
_____Mental Health
_____ Vocational Rehabilitation Counselor
_____Other (indicate) _____

I authorize my noted health care professional to release to Battle Creek Transit, information about my disability and it's affect on my ability to travel which may be needed in connection with my request for paratransit eligibility certification. It is my understanding that the information will used solely to determine my eligibility. I understand that I may revoke this authorization at any time.

Applicant Signature: _____Date:_____