



## DISABILITY IDENTIFICATION CARD APPLICATION For Vacaville City Coach Fixed Route Service

Persons with disabilities are entitled to a discounted fare on the City Coach fixed-route bus system. The Disability ID Card, a Medicare card, or ADA Paratransit ID card must be shown to the driver each time you board the bus to qualify for the reduced fare. If proper ID is not shown, the reduced disabled fare does not apply. Certification is good for three years.

The applicant must return completed application in person or by mail to the Public Works Department at Vacaville City Hall, 650 Merchant Street, Vacaville, CA 95688. Incomplete applications will not be accepted.

### SECTION 1: To be completed by the applicant or by someone on the applicant's behalf. Please print legibly or type.

Applicant's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Birthdate \_\_\_\_\_

I hereby authorize the person listed in Section 2 of this application to release to Vacaville City Coach medical or other pertinent information about my disability. The information released will be used solely to determine my eligibility for this Disability Identification Card.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

### SECTION 2: To be completed by a physician or licensed medical professional, licensed optometrist (for visual impairments), or counselor/social worker (representing a recognized organization for persons with disabilities). Please print legibly or type.

I hereby certify that the applicant qualifies under ADA eligibility requirements to obtain the City Coach Disability Identification Card.

The disability is: \_\_\_\_\_ PERMANENT \_\_\_\_\_ TEMPORARY until \_\_\_\_\_ (date)

I am legally licensed as a:  Physician  Optometrist  Physical Therapist  Chiropractor

Rehabilitation Counselor  Counselor/Social Worker  Other Licensed Professional \_\_\_\_\_

in the State of California and hereby declare that the information provided is true and correct. (specify)

Name \_\_\_\_\_ Signature \_\_\_\_\_

License # \_\_\_\_\_ Date \_\_\_\_\_

Business Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Return this form to the applicant.**