



Doctor Verification for Curb to Curb Service:

We are asking you to provide information regarding your ability to use the **rabbittransit** system. MATP requires **rabbittransit** to provide the least costly mode of service to an individual. The information you provide will allow us to better evaluate your request and provide the most appropriate level of service. Thank you for your cooperation in this matter.

PLEASE NOTE: This allows **rabbittransit** to assist those with disabilities that prevent them from accessing regular public transportation, not persons who find it uncomfortable or difficult to get to and from the bus stop.

DATE: \_\_\_\_\_  
NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

- Can the above names person ride a city bus to travel? YES\_\_\_\_\_ NO\_\_\_\_\_ If you answered NO, please state why? \_\_\_\_\_
- What is the disability that prevents this person from riding the fixed route? \_\_\_\_\_
- Is the disability going to last longer than 12 months? YES\_\_\_\_\_ NO\_\_\_\_\_ If you answered NO, please give a date for expected duration of the disability? \_\_\_\_\_
- In your opinion, how many blocks can this person walk in blocks? \_\_\_\_\_
- Do this person require an escort to travel? YES\_\_\_\_\_ NO \_\_\_\_\_ If you answered YES, please state how this escort assists this person. \_\_\_\_\_

Physician's signature \_\_\_\_\_  
Physician's name \_\_\_\_\_  
(PLEASE PRINT)

Physician's Address \_\_\_\_\_  
Physicians's phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Please mail or fax to:  
**rabbittransit**  
**1230 Roosevelt Ave.**  
**York, PA 17404**  
**Fax # 717-848-4853**