APPLICATION FOR
CENTRAL MIDLANDS REGIONAL TRANSIT AUTHORITY
SPECIAL NEEDS IDENTIFICATION CARD

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: Columbia STATE: SC ZIP CODE: _____

(Physician to complete the box below)

This certifies that the above named individual has been / is my patient and by signing I certify the existence of a debilitating disability that justifiably inhibits the patient's ability to pay the full or standard 25% discounted fare . (Please describe below.)

The applicant's disability is:

___ TEMPORARY (UNTIL _____/_____)
month/year

___ PERMANENT

_____ _____
Physician's Name (print) Physician's Signature

_____ _____ _____
Physician's Phone # Physician's Fax # Date

*** COMPLETED APPLICATIONS SHOULD BE FAXED TO (803) 255-7113 OR MAILED TO:**

CMRTA - SPECIAL NEEDS PASS
PO BOX 214
COLUMBIA, SC 29202

OFFICE USE ONLY

Card Number _____

Issue Date _____