

# 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)

|  |  |                       |
|--|--|-----------------------|
| <p><b>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.)</b></p> |  |                       |
|  |  |                       |
|  |  |                       |
| <p>The applicant's disability is:</p> <p style="text-align: center;"> <input type="checkbox"/> TEMPORARY (UNTIL _____ / _____ )<br/> <span style="margin-left: 150px;">month/year</span> </p> <p style="text-align: center;"> <input type="checkbox"/> PERMANENT         </p>        |  |                       |
| <p>_____<br/>Physician's Name (print)</p>  | <p>_____<br/>Physician's Signature</p> |                       |
| <p>_____<br/>Physician's Phone #</p>   | <p>_____<br/>Physician's Fax #</p>     | <p>_____<br/>Date</p> |

**\* COMPLETED APPLICATIONS SHOULD BE FAXED TO (803) 255-7113 OR MAILED TO:  
CMRTA - SPECIAL NEEDS PASS  
PO BOX 214  
COLUMBIA, SC 29202**

|                        |       |
|------------------------|-------|
| <b>OFFICE USE ONLY</b> |       |
| Card Number            | _____ |
| Issue Date             | _____ |