

BJCTA/MAX
 Recertification Application



Return this application to:

BJCTA-MAX
 Post Office Box 10212
 Birmingham, Alabama 35202-0212
Email: ada@bjcta.org
Fax: (205) 521-0182

Americans with Disabilities Act

The Americans with Disabilities Act states that an eligible individual is an individual with a disability who is unable without the assistance of another individual to board, ride or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities.

APPLICANT INFORMATION

First Name		Last		M.I.	Date	
Street Address				Apartment/Unit #		
City			State		ZIP	
Phone			E-mail Address			

Date of Birth

EMERGENCY CONTACT

First		Last				
Street Address				Apartment/Unit #		
City		State		Zip		
Phone						

Has your condition changed since your last application with max? If so please explain.



This form must be completed and signed by one of the following licensed medical professionals: Physician, Clinical Social Worker, Psychiatrist, Rehabilitation Specialist, Audiologist, Ophthalmologist, Psychologist, Registered Nurse

* Altering statements made by licensed professionals will nullify the "Medical Verification Form" and subsequently the entire application will be returned

APPLICANT INFORMATION				
Date		Date of applicant's last visit		
First Name		Last		M.I.
1. Capacity in which you know the applicant.				
2. Please describe the applicant's impairment/condition in layman's term.				
3. Please describe the impact this impairment/condition has on the applicant's ability to use the fixed route buses.				
4. Is the impairment/condition permanent				
<input type="checkbox"/> Yes		<input type="checkbox"/> No		
5. If temporary, when will the applicant be able to resume normal travel?				
6. Under what circumstances do the impairment/ condition flare up?				
7. How far can the applicant walk without assistance? Please check one.				
<input type="checkbox"/> 300 Feet	<input type="checkbox"/> 500 Feet	<input type="checkbox"/> 600 Feet	<input type="checkbox"/> 1,320 Feet	
8. Does the applicant use any of these mobility devices? Please check all that apply.				
<input type="checkbox"/> White Cane	<input type="checkbox"/> Motorized Wheel Chair	<input type="checkbox"/> Crutches		
<input type="checkbox"/> Braces	<input type="checkbox"/> Cane	<input type="checkbox"/> Scooter		
<input type="checkbox"/> Orthopedic Cane	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Other:		
9. How far can the applicant travel using a mobility device? Please check one.				
<input type="checkbox"/> 300 Feet	<input type="checkbox"/> 500 Feet	<input type="checkbox"/> 600 Feet	<input type="checkbox"/> 1,320 Feet	
10. Does the impairment/condition prevent the applicant from getting to, or from a bus stop?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes		
11. If yes or sometimes please explain.				
12. Does the impairment/condition prevent the applicant from waiting at a bus stop?				
<input type="checkbox"/> Yes		<input type="checkbox"/> No		

13. How long can the applicant wait, if sitting?	Standing?	Using a mobility device?	
Minutes:	Minutes:	Minutes:	
14. Does the weather affect the applicant's ability to travel?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	
15. If yes or sometimes please explain.			
16. Does the applicant have the capability to do the following? Check all that apply.			
<input type="checkbox"/> Give address & phone number	<input type="checkbox"/> Recognize destinations and landmark	<input type="checkbox"/> Deal w/unexpected changes in routes	<input type="checkbox"/> Understand and follow directions
Does the applicant require a (PCA) Personal Care Attendant when traveling by bus?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No		

I certify that the information contained herein is true and correct to the best of my knowledge and ability.

Printed Name:	Signature/Date:	
Professional Title:	Phone:	
Name of Clinic/Agency		
Address:		
City:	St:	Zip:

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