



**Pinellas County Transportation Disadvantaged Program:  
Certification of Need for Transportation by Taxi Cab or Wheelchair Van**

The Pinellas County Metropolitan Planning Organization (MPO), acting as the Community Transportation Coordinator (CTC) for Pinellas County, administers the County's Transportation Disadvantaged (TD) Program. As part of the TD Program, eligible recipients receive either a bus pass, depending on the number of anticipated eligible trips per month and the recipient's ability to access the public transportation system, or transportation via taxi cab or wheelchair van. Eligible trips include travel to medical appointments and other services, pharmacies, grocery stores, utility offices to pay bills, employment, and other sustenance trips. **You have received this form because you have been assigned to the TD bus pass program, based upon the number of eligible trips you anticipate needing this month, but have indicated that you are unable to ride the bus.** In order for us to determine if transportation by taxi cab or wheelchair van would be more appropriate, please complete the top section of the form below and have your physician complete the bottom portion. Once complete, the form should be mailed or faxed back to the address/number located at the bottom of the form.

**Client Information (to be completed by TD Program client):**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

**Physician Certification of Inability to Utilize the Bus System**

*Form must be completed by a licensed physician who is familiar with the client's disability.*

*The CTC is contractually obligated to provide the most appropriate and cost effective form of transportation for eligible TD Program recipients. For recipients who are able to utilize the bus system and have multiple eligible trips each month, the most cost-effective transportation is the bus system. After a beneficiary has been assigned to the bus pass program, they can receive transportation via taxi cab or wheelchair van if a physician certifies that due to a medical diagnosis or disability the person is unable to access or utilize the bus system.*

Physician Name: \_\_\_\_\_ License #/State: \_\_\_\_\_  
Office Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

**Does the TD Program client have a medical condition or disability that would prevent them from accessing or utilizing the bus system? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Describe the medical condition or disability and how it prevents the recipient from accessing and/or utilizing the bus system:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is the condition/disability permanent? Yes \_\_\_\_\_ No \_\_\_\_\_**  
**If No, in your medical opinion, how long will the condition/disability prevent the beneficiary from accessing/utilizing the regular bus system? \_\_\_\_\_ Month(s)**

*I hereby certify that the medical information provided above is true and correct.*

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax or mail completed form to:**  
Community Transportation Services, 13825 Icot Blvd #613, Clearwater, FL 33760  
Phone: 727-545-2100 \* Fax: 727-544-0171