

Healthcare Provider Medical Verification Form

A healthcare provider may also fill out this Medical Verification Form online at www.biokinetix.com/lextran.

**Please mail to: Body Structure Medical Fitness
Attn: Lextran Paratransit
2600 Gribbin Drive
Lexington, KY 40517**

Fax to: (904) 513-9292

Applicant Name:

Date of Birth:

- 1. Please list medical diagnoses or conditions that prevent the applicant from using the Lextran bus independently:**

- 2. Please describe how the applicant's disability prevents them from using Lextran fixed route buses independently:**

- 3. Date of onset:** _____

- 4. Is the applicant's functional limitation permanent?** _____

If no, what is the expected duration: _____

- 5. Does the applicant need a Personal Care Attendant (PCA)?**

If yes, please explain: _____

I certify that I am licensed/certified and am currently treating the applicant listed above.

I certify that all information provided in this application is a fair representation of the applicant's disabilities (or health conditions) and is true and correct.

I understand that the information provided will be used for the purpose of determining the applicant's eligibility for Lextran Wheels paratransit service.

Healthcare Provider Signature

Date

Clearly print your contact information below:

Name: _____ Board Certification # or License #: _____
Phone Number: _____ Fax Number: _____
Business Address: _____