Application for Alternative Wheeled Mobility Devices

Public Transportation, Customer Service Division
TriMet Ticket Office: 701 SW 6th Avenue, Portland, Oregon 97204
Phone: 503-962-2339    Email: hc@trimet.org
Hours: Monday-Friday 8:30 a.m.-5:30 p.m.

To use an alternative wheeled mobility device, a person must complete this application and submit the required medical certification, have the device evaluated by TriMet's ADA Coordinator, and display the blue wheelchair icon sticker that bears the TriMet logo when using the TriMet transit system.

Applicant Information (PLEASE PRINT LEGIBLY)

Name: ..........................................................................................................................................................................................
     First name                                                                               Last name

Mailing Address: .................................................................................................................................................................

Phone #: ..................................................................................................... Date of Birth: .................................................................

Certification of Eligibility section

I certify that I am a person with a disability who uses an alternative wheeled device for mobility.

To qualify to use an alternative wheeled mobility device, you must have the “Health Care Provider's Opinion and Certification” form completed and returned in a sealed envelope from the health care provider's office.

I agree to release the information I am sending to TriMet for the purpose of making this application to use an alternative wheeled mobility device. I certify that the information I provide concerning my application is true and correct. I understand that TriMet reserves the right to require proof of disability in addition to this form.

Signature of Applicant ................................................................................................................................. Date .................................
Health Care Provider’s Opinion and Certification
For individuals with permanent or temporary disabilities

Patient/Applicant Release
I authorize Dr. ........................................................................................... to verify my disability if requested to do so by TriMet.
(Name of Licensed Health care provider*)

Patient / Applicant Signature ........................................................................................................... Date ...............................................................

To be completed by physician or attach benefit information letter

Physician’s name: ................................................................................................................................................

Physician’s license number: ........................................................................................................................................

License issued date: ................................................................................................................................................

Mailing address: ..................................................................................................................................................

Phone number: ...................................................................................................................................................

I, .................................................................................................................... hereby certify that I have examined the patient listed
(Name of Licensed Health care provider*)
above and it is my opinion that he/she is:

☐ Not disabled
☐ Disabled

It is my opinion that he/she ☐ does ☐ does not use an alternative wheeled device for mobility.

☐ Disability is permanent
☐ Temporary
If temporary, what is the duration of this disability?........................................................................................................

I certify that the above is correct and that I am legally licensed under the laws of the State of Oregon to practice medicine.

Physician signature.......................................................... Date..........................................................

Please retain a copy of this form in your files. Customer service staff may contact you for verification. Completed application and Health Care Provider’s Opinion and Certification may be mailed, faxed or hand-delivered by applicant in a sealed envelope from the physician’s office to the TriMet Ticket Office, Customer Service Division, 701 SW 7th Avenue, Portland, OR 97204. Fax: 503-962-2370. Phone: 503-962-2339.