



Disabled Fare Certification Form

For Lextran Use Only
Approval
Issued By
Date

Return to:
Lextran
220 East Vine Street
Lexington, KY 40508

Social Security Number (社会安序号)
Name (姓名)

Physician (医生)
Nature of Disability (残疾性质及程度)

Address (地址)

City (城市) ST (州)

, Counselor
Signature (签字)

Zip (邮编) Phone (电话)

Agency (代理机构)
Address(地址)

Date of Birth (生日) / /

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT IF THIS APPLICATION IS APPROVED, I WILL BE ISSUED AN IDENTIFICATION CARD. IF ISSUED, THIS ID CARD AND/OR THE PASS THAT MAY COME WITH IT, WILL NOT BE LOANED TO ANYONE ELSE.

Signature(签字)

Date (日期)

我证实以上所有信息准确无误并且理解

如果此项申请一经批准，我会得到一张身份认证卡。

身份认证卡和（或）通行证一经发放，我将不会将其借予任何人。