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

Name _____

Address _____

City _____ ST _____

Zip _____ Phone _____

Date of Birth ____/____/____

Physician _____

Nature of Disability _____

_____

_____, Counselor
Signature

Agency _____
Address _____
_____

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 Date

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