ATTACHMENT E
Applicant with Physical Disabilities

Name of Applicant: ______________________________

Name of Licensed Physician: ______________________________

Date Completed: ______________________________

1. In what capacity do you know the applicant?

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2. How long have you known or worked with the applicant?

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3. When did you last see the applicant?

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4. What is the formal diagnosis of the applicant's disability?

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5. What is the date of onset?

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6. What is the prognosis?

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7. How does the applicant's disability / health condition affect daily life activities?

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8. Please define reasonable expectations for each skill (reasonable walking distances, reasonable terrain that can be negotiated, reasonable time that applicant could stand and wait for bus, etc.)

Required Travel Skills	Reasonable Expectations
Walking distance to/from stops	
Stepping on/off curbs and crossing streets	
Negotiating hills/steep terrain	
Standing time at bus stop	
Boarding lift and non-lift buses	
Other	

9. Please define in more detail any environmental issues that may apply (temperature sensitivities - what temperatures would present unsafe or risky conditions for the applicant).

Environmental Issues	Unsafe/Risky Condition(s)
Extreme Heat/Humidity	
Extreme Cold	
Poor Air Quality	
Other	

10. Please list the type, frequency, dose and any comments about how the medications(s) may complicate the individual's independent mobility (travel) in the community.

Medication Type	Dosage	Effect on Functional Ability (if any)

PLACE LICENSE PHYSICIAN OFFICAL STAMP BELOW

General Manager ______________________ Date: ______________

Print Name & Title: ______________________

Current Guam Medical License No. ______________________

Business Address: ______________________

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Mailing Address: ______________________

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Telephone No: ______________________ Fax No. ______________