



Hillsborough Area Regional Transit Authority

www.goHART.org

APPLICATION FOR HART DISCOUNT PERMIT

I hereby submit this application for a HART discount disabled permit for use on HART local bus routes. I hereby authorize HART to verify all the information pursuant to my disability. I understand that these may be limited and are revocable at any time by HART.

Last Name _____ First Name _____ Middle Initial _____

Address _____ Apt.# _____ City _____ State _____ Zip Code _____

Daytime Phone Number _____ Date _____

Male Female Date of Birth _____

SECTION 1 TO BE COMPLETED BY APPLICANT ORIGINALS ONLY

Are you affiliated with any of the following programs?

If yes, please complete all of the information below:

Are you in a structured rehab program? Yes No If yes, Name of Agency _____

Are you currently disabled and under medical treatment? Yes No Name of Provider _____

Do you require use of the wheelchair lift to board the bus? Yes No Wheelchairs must not exceed 30 inches by 48 inches and must not exceed 600 lbs. occupied.

Is your disability temporary? Yes No Length of program: Months _____ Years _____

Is your disability permanent? Yes No

OFFICIAL USE ONLY: Date: _____ Issued Permit Number # _____

COMMENTS: _____ HART REP. _____

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Section 2: TO BE COMPLETED BY A STATE OF FLORIDA CERTIFIED PHYSICIAN OR MEDICAL PROFESSIONAL

(Please Print)
Name of Physician or Medical Professional Office/Agency
Address City FL Zip Code
Mailing Address, if Different
Phone # Fax #
Please provide Physician or Medical Professional License #
Patient/Client's Name Case/ID # Since
TYPE OF SERVICE PROVIDED:
Medical / Mental Health Case Rehabilitation Program / Residential Other

Table with 2 columns: Question and Answer options (Yes/No). Questions include: Did you perform the examination on the above mentioned client? Does the client have a physical or mental disability? Is the client Participating in a rehabilitation program? Is the client a disabled person under treatment? Are you the client's primary provider?

Is the disability Permanent or Temporary? If Temporary, how long?

If you did not perform the examination, how did you verify the client's disability?

I hereby certify that to the best of my knowledge, this application is true and correct and that according to the definition for disabled persons, my patient/client does meet all the requirements for a reduced fare permit.

Signature of Certified Physician or Medical Professional Date

The determination of whether a person is "Disabled" by the definition will be made on the basis of submitted evidence. All applications are subject to HART verification. HART originals accepted only; no copies or faxes permitted.

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