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# Declaration by Medical Professional

Concessionary Disabled Bus Pass Application

A Medical Professional must complete this page.

Please note any fees / charges due as result of supplying this information are to be paid by the applicant.

## Details of applicant

First Name:

Surname:

Date of Birth:

NHS Number:

## Eligibility Criteria

I can confirm that the above-named applicant meets the required eligibility criteria for a concessionary disabled bus pass, on the grounds that they:

(please tick one box only).

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| **Eligibility criteria** | **Yes** |
| **Are Blind.** |  |
| **Are Partially Sighted.** |  |
| **Are Profoundly or severely deaf in both ears.** |  |
| **Are Without speech.** |  |
| **Do not have arms or have long term loss of use of both arms.** |  |
| **Have a significant learning disability. Defined as a “state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.”** |  |
| **Would have their driving licence refused or revoked on the grounds of medical fitness.** |  |
| **Have disability or suffered an injury which has a substantial and long-term adverse effect on their ability to walk without severe discomfort.****Please include in metres the distance the applicant can walk without severe discomfort.** | Metres |

## Any further information

Please add any other information if required.

## Medical Professional Details

Name:

Medical Title:

Contact Address:

Contact Number:

Signature:

Date:

Official Surgery Stamp (Required)

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