

Application for Vista Transit Discount Identification Card

Discounted Fare for seniors, Students and Disabled Riders for Route Service
Separate Application Required for Curbside Service

Return this application with the necessary documentation to the Vista Transit Center, 2050 Wilcox Drive, or mail to Vista Transit 401 Giulio Cesare Ave., Sierra Vista, Arizona 85635. If you have any questions please call the Vista Transit Office at 520-417-4888.

Part I. Applicant Request

Applicant's Name and Address (please print)

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____ Apt. #/Unit: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email: _____

Check the category under which you are applying for Discount I.D. Card:

1. Senior Discount, proof of age 65 or over required.
(Example: Medicare ID Card (white card with red and blue strips), Driver's License, Birth Certificate)
2. Student Discount (class schedule or proof of current enrollment required)
3. Disabled Discount, not eligible for curbside service.
(Examples: Social Security Disability awards letter, Braille Institute ID Card, Disabled Veteran Service ID Card, or Professional Verification. *Please note that documentation must have your name associated with it.*)

Part II. Professional Verification

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Applicant's Name and Address (please print)

Last Name: _____ Date of Birth: _____

1. Is the applicant currently your patient?

Yes No

2. Does the applicant have a functional or cognitive disability?

Yes No

“Cannot perform tasks necessary for bus use including: getting to and from the bus stop, getting on the bus, riding the bus, and understanding how to navigate the system in a variety of environments.” *Note: ADA excludes from eligibility persons whose sole incapacity is pregnancy, obesity, acute or chronic alcoholism/ drug addiction, or contagious disease.*

3. Does this patient's disability prevent them from using Vista Transit's route service safely?

Yes No

HEALTH CARE PROFESSIONAL CERTIFICATION:

In my professional judgment this applicant's disability is: (Check one only)

Permanently Disabled Temporarily Disabled for _____ months.
(Note: Eligibility will not be issued for less than 3 months or more than 3 years)

Name: _____ Date: _____

Address: _____

Telephone #: _____ AZ Professional Lic. #: _____

Fax #: _____

I certify that this information is true and correct to the best of my knowledge.

Physician's Signature: _____