Card Number: _____

Certification Date: _____

TAR RIVER TRANSIT

S.N.A.P. CARD (SPECIAL NEEDS ASSISTANCE PROGRAM)
APPLICATION

PART I – TO BE COMPLETED BY APPLICANT(Please print or type)

1. Name _____MALE / FEMALE
(Last) (First) (Initial) (Circle one)

2. ADDRESS _____

3. TELEPHONE NUMBER: _____ SOCIAL SECURITY: _____

4. AGE: (Check one) _____ Less than 60 years old _____ 60 years or older

I hereby certify that the information provided above and that provided by me to the authorized physician is true and correct:

_____ _____
Applicant's Signature Date

PART II – TO BE COMPLETED BY PHYSICIAN (Please print or type)

1. I certify that the above-named individual suffers from a physical disability to use regular fixed route bus service.

The person's disability can be described as: _____

_____

_____

2. Please describe how the disability impairs the person's ability to use fixed route bus service:

_____

_____

3. The person's disability is expected to last until: _____

_____
PHYSICIAN'S SIGNATURE

_____
PHYSICIAN'S NAME PRINTED

_____
ADDRESS

_____
TELEPHONE NUMBER

PART III – TO BE COMPLED BY THE TRANSIT ADMINISTRATOR
DETERMINATION:

_____

CERTIFICATION DATE: _____

RETURN TO : TAR RIVER TRANSIT P. O. BOX 1180 ROCKY MOUNT, NC 27802
(252) 972-1174