PARIS METRO
PARATRANSIT APPLICATION

Complete this form and return it to: Ark-Tex Council of Governments
240 10th SE Bldg. 5, Paris, TX 75461
844-437-7497 or 903-739-2444 EMAIL to: srecord@atcog.org

The bottom part of this form MUST be completed by a Medical Professional

NAME (Last, First, Middle Initial)	**Phone # Home:** **Cell:**	**Date of Birth**
Street Address, City, State, Zip Code		
Personal Care Attendant Needed? **YES ☐ NO ☐**	**Do you use a wheelchair? ☐ YES ☐ NO** **Manual ☐ Electric ☐ Scooter ☐ YES ☐ NO**	
Do you use a guide dog? **☐ YES ☐ NO**	**Do you use a cane?** **☐ YES ☐ NO**	**Do you use a walker?** **☐ YES ☐ NO**
Person to notify in case of emergency **Name_____ Phone No. _____** **Applicant Signature: Date:**		
If application is being completed by someone other than the applicant, please sign here **Name: Relationship:**		
******THE SECTION BELOW MUST BE COMPLETED BY MEDICAL PROFESSIONAL******		
Disability/Medical Diagnosis **(Define WHY applicant cannot ride the fixed route bus system in detail)** _____		
Is a Personal Care Attendant required? **☐ YES ☐ NO**	**Weight of Client ☐ Standard ☐ Oversized** **& Wheelchair: _____ pounds**	

Medical Prof #	**Facility Name**	**Verifying Professional Name**	**Verifying Prof Signature**

FOR PARIS METRO OFFICE USE ONLY	
Authorized by & Date	**☐ APPROVED ☐ New ☐ Recertification** **☐ DENIED (If checked, complete next line)**
Please state reason for denial	

ANY APPLICANT WHO IS DENIED ELIGIBILITY ARE GIVEN UP TO 60 DAYS TO APPEAL THE DECISION IN WRITING