

Professional's Name: \_\_\_\_\_

APPLICANTS NAME: \_\_\_\_\_ DOB \_\_\_\_\_

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**THESE TWO PAGES MUST BE FILLED OUT BY PROFESSIONAL**

North Oakland Transportation Authority (NOTA) requires verification by a professional in order to qualify disabled individuals requesting service for transportation. Please fill in all sections that pertain to the applicant's disabilities as they relate to using public transportation. If you have any questions, please call (248) 693-7100. **Please return this form to:**

**Fax: 248-693-7270 or mail to: 675 S. Glaspie St., Oxford, MI 48371**

1. What is your professional relationship to the applicant? Nurse Practitioner  
Other:
2. What is/are the applicant's disabilities/diagnosis?:
3. Is this disability temporary?: No      If yes, until:
4. Please check the mobility aid(s) that the applicant uses to your knowledge: Power Scooter  
Other:
5. Is the applicant legally blind?: No
6. Does the applicant have a cognitive disability?: No
7. Does the applicant exceed 400 pounds? (Bus lift restriction)?: No
8. Is the applicant able to:
  - a. Give address and telephone numbers upon request?: Yes
  - b. Recognize a destination or landmark : Sometimes
  - c. Deal with unexpected change in routine?: Sometimes
  - d. Ask for, understand and follow directions?: Sometimes

# NOTA REQUEST FOR PROFESSIONAL VERIFICATION | 2020

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9. Please explain any SOMETIMES responses from question #8 above or describe any other effects of the disability not already provided elsewhere on this form.:

YOUR NAME: \_\_\_\_\_

TITLE/POSITION: \_\_\_\_\_

PERMANENT PROFESSIONAL LICENSE/ID# \_\_\_\_\_

NAME OF ORGANIZATION: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_ APT # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

OFFICE PHONE: \_\_\_\_\_

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I hereby certify that the information given above and in this application is correct.

Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN FAX FORM TO: 248-693-7270 OR**

**Or MAIL TO:**

**NOTA, 675 S. Glaspie St., Oxford, MI 48371**