MITSPlus Application & Authorization to Release Information Regarding Eligibility for MITSPlus

To be completed by **Applicant**. Please print clearly.

I understand that to be certified to use MITSPlus under the guidelines of the Americans with Disabilities Act (ADA) I must have a disability which makes me unable to use MITS fixed route bus service. Unable means that it is impossible or it causes severe or continuing pain. I understand that discomfort, occasional pain, age, or distance to the nearest bus stop do not by themselves constitute an ADA eligible disability.

I hereby authorize the professional listed below to provide information to MITS regarding my ability to use MITS fixed route bus service. I understand that all information will be kept confidential.

Applicant's Signature ______________________ **Date** __________

Print Name ______________________

Street Address ______________________

Mailing Address ______________________

City ______________________ **Zip code** __________

Telephone: Home ______________ **Work** ______________

Cell ______________ **Email address** ______________

Accessible format materials required? _____ Braille _____ Large Print _____ Computer Disk

The professional identified below must be one of the following currently licensed professionals: registered nurse, physician, clinical social worker, psychologist, physical therapist, occupational therapist, speech pathologist, vocational rehabilitation specialist, recreation therapist, or orientation mobility instructor.

Name of professional ______________________

Clinic or agency ______________________

Street address ______________________

City ______________________ **Zip** __________

Telephone ______________________

In case of emergency, contact:

Name ______________________

Street address ______________________

Telephone: Home ______________ Work ______________

Cell ______________ Email address ______________

Relationship to applicant ______________________

If this application has been completed by someone other than the applicant:

Signature ______________________ Date __________

Print name ______________________

Street address ______________________

City ______________________ Zip __________

Telephone: Home ______________ Work ______________

Cell ______________ Email address ______________

Relationship to applicant ______________________

Return completed form to:
MITSPlus, 1300 E Seymour St, Muncie IN 47302

Original –MITSPlus office Carbon