Baltimore City Health Department Division of Aging & CARE Services

TaxiCard Registration Form

PHYSICIAN'S STATEMENT

This form must be completed for all **applicants with disability under 60 years of age.**

I hereby certify and affirm that _____has the following
(Applicant's Name)
disability which severely limits mobility:

_____

_____

_____

Applicant mobilizes with the use of:

_____ Wheelchair at all times _____ Wheelchair occasionally
_____ Cane _____ Walker

_____ _____
Doctor's Name (Printed) Doctor's Signature

_____ _____
Office Street Address Suite City State Zip code

_____ _____
Office Telephone Number Office Fax Number

_____
Type of Doctor (Licensed Physician, Licensed Chiropractor, Licensed Podiatrist, Licensed Optometrist)

_____ _____ _____
Medical License Number State of Issue Expiration Date

Neither the services nor the use of the Baltimore City Health Department Aging and Care Services facilities are denied to any person on the basis of race, color religion, national origin, ancestry, sexual orientation, gender or disability.

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