ROCKFORD MASS TRANSIT DISTRICT

APPLICATION FOR RMTD DISABLED CITIZEN PHOTO ID

NAME:_____
FIRST MIDDLE LAST

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

TELEPHONE:_____ BIRTH DATE:_____

AI certify that the above infomation is correct. In the event that I discontinue using the DISABLED CITIZEN PHOTO ID, I will return the ID to Rockford Mass Transit District. I will not loan my card to anyone, and I understand that if I do so, my card can be revoked.@

SIGNATURE:_____ DATE:_____

Verification signature (either doctor or director of disabled agency along with name and address of agency or doctor=s office).

SIGNATURE:_____ DATE:_____

ADDRESS:_____

RMTD OFFICE USE ONLY:

MEDICARE CARD YES:_____ VERIFIED:_____ DIS.SUP.:_____

NO:_____ FEE PAID:_____