APPLICATION FOR RMTD DISABLED CITIZEN PHOTO ID

NAME: _____
FIRST **MIDDLE** **LAST**

ADDRESS: _____

CITY: _____ STATE: _____ZIP_____

TELEPHONE: _____ BIRTHDATE: _____

I certify that the above information is correct. I understand that this pass is valid for 2 years. 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. I understand that it is not transferrable. I understand that if I do so or violate any of the District's rules and/or policies, my card can be revoked.

SIGNATURE: _____DATE: _____

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

SIGNATURE: _____ DATE: _____

ADDRESS: _____

RMTD OFFICE USE ONLY:

MEDICARE CARD YES: _____ VERIFIED: _____