TOPS! Paratransit Eligibility

Form C: Epilepsy or Seizure Disorder

To be completed by a Licensed Health Care Provider

Applicant's Name: _____ Date of Birth: _____

1. Type of Seizure: _____
2. Seizure Frequency: _____
3. Does the seizure alter consciousness or awareness? ☐ Yes ☐ No
4. Please specify the behaviors exhibited during/following the applicant's seizure? _____

   _____
5. Would applicant be able to travel independently on fixed-route buses if they are medication compliant? ☐ Yes ☐ No
6. Is applicant's functional limitation permanent? ☐ Yes ☐ No
   If no, expected duration? # of Months_____ # of Years_____
7. For safety reasons, does the applicant need to travel on TOPS! at all times, with a PCA? ☐ Yes ☐ No If yes, please explain:

   _____

   _____
8. For safety reasons, can applicant be left unattended at pickup or drop-off locations? ☐ Yes ☐ No If no, please explain:

   _____

   _____

I certify the information provided above is correct.

_____ _____

Signature of Licensed Health Care Provider Date

Clearly print your contact information below:

Name: _____ Board cert. # or Lic. #:_____

Phone #: _____ Fax #: _____

Business address: _____