TOPS! Paratransit Eligibility
**Form B: Vision**

To be completed by a Licensed Eye Care Professional or
Certified Orientation and Mobility Specialist (OMS) Provider

Applicant's Name: _____ Date of Birth: _____

1. Please state applicant's Visual Impairment: _____
2. Applicant's best corrected Visual Acuity: OS_____ OD_____
3. Date of onset: _____
4. Is applicant's functional limitation permanent? ☐ Yes ☐ No
   If no, expected duration: # of Months _____ # of Years _____
5. How does applicant's disability, combined with any environmental barriers, prevent independent use of the fixed-route bus service?
   _____
   _____
6. For safety reasons, does the applicant need to travel on TOPS! at all times, with a PCA? ☐ Yes ☐ No If yes, please explain:
   _____
   _____
7. 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 Eye Care Professional / OMS Date

**Clearly print your contact information below:**
Name: _____ Board cert. # or Lic. #:_____
Phone #: _____ Fax #: _____
Business address: _____