



Call-n-Ride  
101 Monroe Street, 5<sup>th</sup> Floor  
Rockville, MD 20850

**Call-n-Ride MENTAL HEALTH ATTACHMENT**

For applicants aged 18-66, this form **MUST** be completed by a **licensed mental health physician** to qualify for Call-n-Ride under a mental disability. All information has to be complete, detailed, and verifiable. By signing below Call-n-Ride Applicant and the certifying Physician agree to provide more information, if and when required by the Montgomery County Call-n-Ride Program. **PLEASE PRINT.**

**THE FOLLOWING SECTION SHOULD BE COMPLETED BY A LICENSED PHYSICIAN**

1. I recommend certification of \_\_\_\_\_ for the Call-n-Ride program.  
*(Applicant's Name)*
2. Please circle the category of the disability:  
A. Developmental Disability B. Chronic Mental Illness C. Head Injury D. Other
3. What is the patient's diagnosis (Provide Details)? \_\_\_\_\_  
\_\_\_\_\_
4. Is the disability Permanent or Temporary? \_\_\_\_\_
5. If temporary how long do you anticipate it to last? \_\_\_\_\_

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Professional License #

\_\_\_\_\_  
Issuing state

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Agency

I certify and affirm that the applicant identified above has a MENTAL DISABILITY. I also certify and affirm that all information presented in this form is true and correct. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

**THE FOLLOWING SECTION TO BE COMPLETED BY THE APPLICANT**

I certify and affirm that all information presented in this form is true and correct. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation. I also authorize Call-n-Ride Program representatives to verify my health information, as it pertains to this certification only, with the above mentioned physician.

\_\_\_\_\_  
Patient's / Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's / Guardian's Name (*PLEASE PRINT*)

\_\_\_\_\_  
Guardian's Relationship to Patient

Patient's / Guardian's Address and Phone #  
\_\_\_\_\_  
\_\_\_\_\_

**CALL-n-RIDE OFFICE USE ONLY:**

Date \_\_\_\_\_ Verified?  YES  NO If NO, why? \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_  
Initials: \_\_\_\_\_