In order to be eligible to ride the bus at the half fare rate for individuals with disabilities, the enclosed form must be neatly filled out and the doctor's portion must be *signed and returned by a physician* certifying the existence of a debilitating disability that justifiably inhibits your ability to pay the full fare. Applications not sent by the physician will be returned upon receipt.

Ask your physician's office to mail or fax the completed form to:

The Comet
Central Midlands Transit
Attn.: Half Pass Program
P.O. Box 214
Columbia, SC 29202

FAX: (803) 255-7113

When we receive the information, someone will contact you to set up an appointment to take your photo and make the Half Pass Identification Card. You will receive the Half Pass Identification Card at that time.

APPLICATION FOR

HALF PASS PROGRAM IDENTIFICATION CARD

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE # (_____) _____ - _____

CITY: _____ STATE: SC _____ ZIP CODE: _____

(Physician to complete the box below)

This certifies that the above named individual has been / is my patient and by signing I certify the existence of a debilitating disability that justifiably inhibits the patient's ability to pay the full fare or prepurchased discount fare pass . (Please describe below.)

_____

_____

_____

The applicant's disability is:

___ TEMPORARY (UNTIL _____/_____) month/year

___ PERMANENT

_____ _____

Physician's Name (print) Physician's Signature

_____ _____ _____

Physician's Phone # Physician's Fax # Date

*** COMPLETED APPLICATIONS SHOULD BE MAILED TO:**

THE COMET/CMRTA
HALF FARE PROGRAM
PO BOX 214
COLUMBIA, SC 29202

FAX: (803) 255-7113

OFFICE USE ONLY

Card Number

Issue Date