VERIFYING PHYSICIAN COMPLETED AND RETURN TO:

2919.

MAYOR'S OFFICE P.O. BOX 727 630 S. CENTRAL AVE., 7<sup>TH</sup> FLOOR MARSHFIELD, WI 54449-0727 FAX: 715-384-9310

## APPLICATION FOR DISABLED PERSONS FOR REDUCED TAXI FARES

NAME	
STREET ADDRESS	
CITY, STATE ZIP	
I hereby authorize	to release information
necessary to complete this application.	
Signature of Application	Date
DOCTOR'S VERIFICA	<u>ATION</u>
is eligible for r this person was based on the applicant's physical or menta	
This limitation is permanent or temporary.	
If temporary, this limitation is for a period of	
Doctor's Signature	Date
Upon receipt of this application the City of Marshfield will card qualifying you for reduced fare. For additional information	· · · · · · · · · · · · · · · · · · ·