**CATCAB REFERRAL FORM**

This form serves as a referral for the need of services provided by Ohio University Transportation and Parking Services (TPS). Any individual wishing to receive CATCAB services must have this form completed by their health care professional or by Institutional Equity prior to services being offered. If you have any questions, please contact Transportation Services at 740-593-1917 between the hours of 7:30 AM and 4:30 PM. This referral may be faxed to our offices at 740-593-9608.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Personal Information** | | | | |
| Last Name | First Name | | M.I. | |
| Local Address | | City | | Zip |
| Email Address | | | | |
| Preferred Phone # | | | | |

|  |  |  |
| --- | --- | --- |
| **Please Indicate All that Apply** | **Temporary Authorization** | |
| Unable to walk without the use of or assistance from:   * Crutches, Cane * Walker * Boot, Brace * Wheelchair * Attendant, Assistant * Other: | Beginning Date | Ending Date |
| Note – All permanent authorizations must go through Student Accessibility Services for any student rider. | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Health-Care Provider** | | | |
| Last Name | First Name | | M.I. |
| Office Address | | Office Phone # | |

|  |  |
| --- | --- |
| **Signature** | |
|  | Date |