



# GUAM REGIONAL TRANSIT AUTHORITY

## GOVERNMENT OF GUAM

Lourdes A. Leon Guerrero, Governor  
Joshua F. Tenorio, Lieutenant Governor  
Tyrone J. Taitano, Interim Executive Manager



Dear Applicant,

***Hafa Adai!*** Thank you for inquiring about the Guam Regional Transit Authority's (GRTA) ADA Paratransit Services. Attached is GRTA's ADA Paratransit Application Form. **Please read all the enclosed material carefully before completing the application form.**

GRTA's ADA Paratransit service is provided to individuals who, because of a **disability, are unable to use** the standard Guam Public Transit System Fixed Route Services. This might include being unable to reach or depart from bus stops, board or alight from buses, or understand how to ride and use the system.

GRTA will provide paratransit service to persons determined to be "ADA Paratransit Eligible" for those trips that cannot be made using the Guam Public Transit System. You may, for example, be able to use the Guam Public Transit System for some trips if stops are nearby and there are no barriers that prevent you from getting to and from the bus. [At other times, you might be able to get to and use the bus; ADA Paratransit Services is meant to assist you at these times.]

There are two (2) types of ADA Paratransit Eligibility. These are:

- \* **Unconditional** - An individual who is unable to use fixed route transit services under any circumstances requires unconditional eligibility, allowing the individual to make all trips using complementary paratransit.
- \* **Conditional** - An individual may be able to use the fixed route system for some trips. Transit agencies can establish conditional eligibility for individuals and would only be obligated to provide complementary paratransit for trips the individuals cannot make using the fixed route, based on the conditions of the particular trip [Section 37.123(b)].

To enable us to accurately determine your eligibility for this service, please fill out the enclosed application form **as completely and thoroughly as possible**. The questions are meant to determine the specific limitations you have in using the Guam Public Transit System. They are also meant to determine **when and under what circumstances you can use the Guam Public Transit System buses or when GRTA's Paratransit Service is required**.

After you have completed parts 1-6, please have a Guam-licensed physician, Health Care Professional, or Social Worker complete Part 7 of the application with an official stamp. This will certify your disability, but does not necessarily determine your eligibility for GRTA's Paratransit Service. It is important that all sections of the application form are complete. **If any sections are left blank, the form will be returned to you.**

**Information about your disability which provide in the application will be kept strictly confidential.**

If you need assistance in completing the application form, or have questions about GRTA's ADA Paratransit Services and Eligibility, please feel free to contact our office at:

671-475-4686 /475-4616 (Office)  
671-475-4600 (Facsimile)

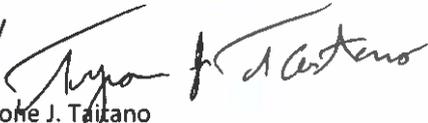
Material is also available in large print and can be provided in another format if needed. Please call our office and inform our staff of the format you require.

Completed applications will be processed within twenty-one (21) calendar days of receipt. You will be notified via phone call of your eligibility for GRTA's ADA Paratransit Services. Please note that in some instances, we may not be able to determine your eligibility without further information. In this case, we may ask you to schedule an In-Person Assessment to better understand your disability and transportation needs.

If you are determined to be eligible for GRTA's ADA Paratransit Services (either Unconditional or Conditional), an "ADA Directives", which provides information about the services and how to use them, will be provided to you during the In-Person Assessment or will be sent to you at the address you provided in the application. GRTA staff will take your picture for your Paratransit Riders Identification Card here in our office.

If it is determined that you are able to use the Guam Public Transit System and therefore are not eligible for GRTA's Paratransit Services, we will notify you in writing of the exact reasons for this determination.

Sincerely,

/s/   
Tyrohe J. Taitano  
Interim Executive Manager

Attachments



**PART 1. GENERAL INFORMATION**

<b>FOR OFFICIAL USE ONLY</b>			
Type:	<input type="checkbox"/> New	<input type="checkbox"/> Renewal	<input type="checkbox"/> Recertification
ID No:	_____		
Date Issued:	_____		
Date of Expiration:	_____		

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Address: \_\_\_\_\_ Village: \_\_\_\_\_

Telephone No: (Home): \_\_\_\_\_ (Cell/Work): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

If someone assisted you in completing this form, please identify them below:

Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Do you need to have information and material given to you in any of the following ways (check all that you need):

- Large Print
- Audio Tape
- Braille
- Other

Please give us the name and telephone number of someone we can call in an emergency.

Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Relationship: \_\_\_\_\_

Ethnic Origin:

- Non-Resident Alien
- Hispanic or Latino
- White (Not Hispanic or Latino)
- Black or African American
- Asian (Not Hispanic)
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander:  Hawaii  Guam  CNMI  Palau
- FSM Citizen:  Chuuk  Pohnpei  Yap  Kosrae  Other \_\_\_\_\_

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## **PART 2. APPLICATION CERTIFICATION**

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**Please indicate below the reason(s) why you are seeking ADA Paratransit Eligibility (check all that apply):**

- I can use the Guam Public Transit System (Fixed Route) to go some places, but in other places I cannot get to or from the bus stop.
- I can use the Guam Public Transit System (Fixed Route) sometimes, but only if buses are equipped with wheelchair lifts
- Because of my disability, I can never use the Guam Public Transit System.

I understand that the purpose of this evaluation form is to determine if there are times when I cannot use the Guam Public Transit System provided by the Guam Regional Transit Authority (GRTA) and must therefore use GRTA's Paratransit Service. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility to use the GRTA's Paratransit Service. I certify that, to the best of my knowledge, the information in this evaluation form is true and correct. I understand that providing false or misleading information could result in my eligibility status being re-examined as well as other actions deemed necessary by the Guam Regional Transit Authority (GRTA).

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **PART 3. INFORMATION ABOUT THE APPLICANT'S DISABILITY**

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**1. What type or types of disabilities prevent you from using the Guam Public Transit System (Fixed Route) (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Physical Disability      | <input type="checkbox"/> Visual Impairments/Blindness |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Mental Illness               |
| <input type="checkbox"/> Other                    | <input type="checkbox"/> None                         |

**Please describe your disability in detail:** \_\_\_\_\_

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2. Is the disability described above temporary or permanent?

- Temporary, I expect it to last for another \_\_\_\_\_ months
- Permanent
- Controlled with medication
- I don't know

3. Please indicate below if you use any of the following mobility aids or equipment.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cane  | <input type="checkbox"/> Long White Cane      | <input type="checkbox"/> Picture Board      |
| <input type="checkbox"/> Crutches                                      | <input type="checkbox"/> Walker               | <input type="checkbox"/> Powered Wheelchair |
| <input type="checkbox"/> Alphabet Board                                | <input type="checkbox"/> Manual Wheelchair    | <input type="checkbox"/> Prosthesis         |
| <input type="checkbox"/> Powered Scooter                               | <input type="checkbox"/> Leg Braces           |   |
| <input type="checkbox"/> Other _____                                   | <input type="checkbox"/> Service Animal _____ |   |
| <input type="checkbox"/> DO NOT USE any of the above aids or equipment |   |   |

**NOTE: GRTA may not be able to accommodate you if your wheelchair/scooter is longer than 48" or wider than 32" or if your total weight with your wheelchair is more than 600 pounds.**

4. Do you require assistance of a Personal Care Attendant (PCA) (someone who will assist you with daily life functions when you travel)?

- Yes
- Always
- Sometimes

Name of Personal Care Attendant: \_\_\_\_\_  
(Print)

DO NOT NEED ASSISTANCE

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## **PART 4. QUESTIONS ABOUT USING THE GUAM PUBLIC TRANSIT SYSTEM**

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5. Have you ever used the Guam Public Transit System?

- Yes, I typically use the Guam Public Transit System \_\_\_\_\_ a week
- Yes, I used to but stopped because \_\_\_\_\_
- No

6. Is there something that might help you ride the buses (check all that apply)?

- Yes, Route and schedule information
- Yes, learning to use the buses
- Yes, being able to get buses with lifts
- Yes, a communication aide
- Yes, if stops were closer to where I live and where I need to go
- Yes, (describe) \_\_\_\_\_
- No

7. Can you ask for and follow written or oral instructions to use the Guam Public Transit System?

- Yes
- No
- Sometimes
- I don't know, never tried to use the buses

**If No or Sometimes, please check all that apply:**

- I get too confused and might get lost
- Other people cannot understand me
- I probably could with instruction
- Other \_\_\_\_\_

8. Are you able to GET TO and FROM bus stops on your own?

- Yes
- No
- Sometimes
- I don't know, never tried to use the buses

**If No or Sometimes, please check all that apply:**

- I can't get places if there are no curb-cuts
  - I can't of streets or sidewalk is too steep
  - I can't cross busy streets & intersections
  - I can't travel outside when it is too hot
  - I can't find my way at night because of a vision problem
  - I get confused and can't find my way
  - I probably could with instruction
  - I feel unsafe traveling alone
  - Other \_\_\_\_\_
-

9. Under the best of conditions, how far can you walk outdoors (or travel using a mobility aide) without the help of another person?

- I can get to the curb in front of my house/apartment
- I can travel up to three (3) blocks (1/4 mile)
- I can travel up to six (6) blocks (1/2 mile)
- I can travel up to nine (9) blocks (3/4 mile)
- I am unable to travel outside my house/apartment

10. Can you wait up to thirty (30) minutes for a Guam Public Transit System Bus?

- Yes
- Yes but only if the stop has a bench and shelter
- Yes but I do not like to wait long
- No (explain): \_\_\_\_\_

11. Can you Get On and Off a Guam Public Transit System Bus?

- Yes
- No
- Sometimes
- I don't know, never tried to use the buses

If No or Sometimes, please check all that apply:

- Only if the bus has a wheelchair lift
- I can't climb stairs
- I don't want to use the lift
- I probably could with instruction
- Other \_\_\_\_\_

12. If you are able to get on and off the Guam Public Transit System Bus, can you get to a set or wheelchair position by yourself and ride the bus?

- Yes
- No
- Sometimes
- I don't know, never tried to use the buses

If No or Sometimes, please check all that apply:

- I need someone to help me
- I have a balance problem
- I have trouble finding a seat
- I need the seat nearest the door
- Other \_\_\_\_\_

13. If you are able to get on and off the Guam Public Transit System Buses, do you know where to get off the bus or can you find out by yourself?

- Yes
- No
- Sometimes
- I don't know, never tried to use the buses

If No or Sometimes, please check all that apply:

- I get confused and can't remember where I am going
- I can if the driver calls out the stops
- I probably could with training
- Other \_\_\_\_\_

14. Are there any other conditions which limit your ability to use the Guam Public Transit System Buses?

Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

No

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## PART 5. CURRENT TRAVEL INFORMATION

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15. Please give us information about where you go and how you get there now. List three (3) places you go most often.

1. Where do you go? \_\_\_\_\_

Address: \_\_\_\_\_

How often do you go there? \_\_\_\_\_

How do you get there? \_\_\_\_\_

2. Where do you go? \_\_\_\_\_

Address: \_\_\_\_\_

How often do you go there? \_\_\_\_\_

How do you get there? \_\_\_\_\_

3. Where do you go? \_\_\_\_\_

Address: \_\_\_\_\_

How often do you go there? \_\_\_\_\_

How do you get there? \_\_\_\_\_

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## PART 6. INFORMATION ABOUT TRAVEL TRAINING (Survey-Data Collection Purpose Only)

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**NOTE: Travel training is personal (one-to-one) instruction that teaches an individual how to use the Guam Public Transit System Buses.**

16. Have you ever had any personal instruction on riding the Guam Public Transit System?

No, I have not received any personal instruction

Yes, I received personal instruction from \_\_\_\_\_

If so, indicate below all of the skills you learned.

To travel to and from the bus stop

To cross streets

To ride on the following routes (list them)

Route: \_\_\_\_\_ Route: \_\_\_\_\_

Reading bus schedules and planning trips

Other \_\_\_\_\_

Did you complete the above described instructions?  Yes  No

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17. Please draw a map to your residence. A Transit Inspector will be by to address your area for bus access. (Note: Buses are NOT allowed to enter non-paved roads and single narrow access roadways.)

Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Home Address: \_\_\_\_\_

**This ends the portion of the application to be completed by the Applicant. The last section (on the attached pages) MUST BE completed by a Guam Licensed Physician.**

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**PART 7. MEDICAL CERTIFICATION (To be completed by a Licensed Physician)**

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The American with Disabilities Act (ADA) of 1990 requires the Guam Regional Transit Authority (GRTA) to provide "ADA Paratransit Services" to anyone with a disability **who cannot use the standard Guam Public Transit System Fixed Route Services** and who is traveling within a 3/4 mile area served by Fixed Route Services. The applicant who requests you to review and sign this form is applying at GRTA to be considered eligible for this service. GRTA's ADA Paratransit Service is intended only for those trips on the Guam Public Transit System that the person cannot access.

This application form is intended to determine **when and under what circumstances the applicant can use GRTA's Guam Public Transit System - Paratransit Services.**

Please carefully review all the information provided by the applicant in Parts 2-4 of this form and then complete the appropriate "Attachment" below:

(a) Please complete all the appropriate assessment forms that best describes the physical and/or cognitive conditions which functionally prevents the applicant from using the standard Guam Public Transit Fixed Route Services System.

Attachment A: Applicant with Cognitive Disabilities

Attachment B: Applicant with Psychiatric Disabilities

Attachment C: Applicant with Vision Disabilities

Attachment D: Applicant with Seizure Disorders

Attachment E: Applicant with Physical Disabilities

(b) To the best of your knowledge, the information provided by the applicant in Parts 2-4 of this application is true and correct?

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**ATTACHMENT A**  
**Applicant with Cognitive Disabilities**

**Name of Applicant:** \_\_\_\_\_

**Name of Licensed Physician:** \_\_\_\_\_

**Date Completed:** \_\_\_\_\_

1. In what capacity do you know the applicant?

\_\_\_\_\_  
\_\_\_\_\_

2. How long have you known or worked with the applicant?

\_\_\_\_\_  
\_\_\_\_\_

3. When did you last see the applicant?

\_\_\_\_\_  
\_\_\_\_\_

4. Comments about the applicant's stated ability and level of cognitive ability?

\_\_\_\_\_  
\_\_\_\_\_

5. Does the applicant have specific behavioral problems?

Yes       No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

6. Does the applicant travel alone at times?

Yes       No

If so, where: \_\_\_\_\_

\_\_\_\_\_

7. What abilities does the applicant have to follow directions to make a trip?

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8. What abilities does the applicant have to understand time and follow a schedule to get to places on time?

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9. What abilities does the applicant know when he/she is lost?

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10. What abilities does the applicant have to get help if he/she is lost?

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11. What ability does the applicant have to cross a street safely?

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12. Comments about the applicant stated ability to travel alone.

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13. Comments about skills related to functional abilities to travel: Orientation to person, place and time

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14. Comments on applicant judgement and safety skills related to traveling alone.

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15. Comments on problem solving and insight skills.

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16. Comments on short-term and long-term memory.

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17. Comments on concentration (focus attention).

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18. Comments on ability to seek and act on direction.

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19. Comments on ability to process information.

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20. Comments on consistency (the ability to maintain a particular standard or repeat a particular task with minimal variation).

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21. Comments on ability to communicate needs.

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22. Comments on behavioral skills

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23. Comments about applicants related physical skills that may affect travel (i.e. walking stability - gait, balance; physical stamina-endurance, or seizures)

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**PLACE LICENSE PHYSICIAN OFFICAL STAMP BELOW**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Ethnic Origin: \_\_\_\_\_

Print Name & Title: \_\_\_\_\_

Current Guam Medical License No. \_\_\_\_\_

Business Address: \_\_\_\_\_  
\_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone No: \_\_\_\_\_ Fax No. \_\_\_\_\_

**ATTACHMENT B**  
**Applicant with Psychiatric Disabilities**

**Name of Applicant:** \_\_\_\_\_

**Name of Licensed Physician:** \_\_\_\_\_

**Date Completed:** \_\_\_\_\_

1. In what capacity do you know the applicant?

\_\_\_\_\_  
\_\_\_\_\_

2. How long have you known or worked with the applicant?

\_\_\_\_\_  
\_\_\_\_\_

3. When did you last see the applicant?

\_\_\_\_\_  
\_\_\_\_\_

4. What is the formal diagnosis of the applicants disability (DSM-IV or other)?

\_\_\_\_\_  
\_\_\_\_\_

5. What was the date of onset?

\_\_\_\_\_  
\_\_\_\_\_

6. What is the prognosis?

\_\_\_\_\_  
\_\_\_\_\_

7. Is the applicant taking any psychotropic, antidepressant or other medication(s) prescribed by you?

Yes       No

8. If Yes, please list the type, frequency, dose and any comments about how the medication(s) may complicate the individual's independent mobility in the community?

Medication Type	Dosage	Effect on Functional Ability (if any)

9. If the applicant takes his/her medication compliantly, will he/she be able to travel independently in the community?

Yes       No

Comments: \_\_\_\_\_  
\_\_\_\_\_

10. Do you deem the applicant to be compliant in taking prescribed medication?

Yes       No

Comments: \_\_\_\_\_  
\_\_\_\_\_

11. Is there anything about the use of medication that would complicate the applicant's use of public transportation?

Yes       No

Comments: \_\_\_\_\_  
\_\_\_\_\_

12. Has the applicant's functional ability decreased temporarily due to adjustment to medication?

Yes       No

13. If Yes, please explain and note the expected duration of the decrease in functional ability.

\_\_\_\_\_  
\_\_\_\_\_

14. Does the applicant currently experience either auditory or visual hallucinations?

Yes       No

15. If Yes, would he/she likely to experience auditory or visual misperceptions due to hallucinations?

Yes       No

Comments:

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**General Manager**

	Yes	No	Sometimes	Comments
Travel alone outside the house				
Leave the house on time				
Seek and act on directions				
Find way to/from bus stop				
Cross Streets				
Wait for a bus				
Board the correct bus				
Ride on the bus				
Exit at the correct destination				
Transfer to a second bus				
Monitor time				
Deal with unexpected situations				

Comments:

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17. Are any of the following affected by his/her disability? If Yes, please explain:

	Yes	No	Sometimes	Comments
Judgement				
Problem Solving				
Insight (recognizing a problem)				
Coping skills				
Short-term memory				
Long-term memory				
Concentration				
Orientation				
Communication				
Attention to task (distractability)				

Comments:

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18. Would training, driver assistance or tools such as ID cards, printed route directions, etc., help to minimize the effects noted above?

Yes       No

Comments:

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19. Is the goal of traveling independently (even limited travel in the neighborhood) within the context of treatment?

Yes       No

Comments:

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20. Would the use of alternative transportation (ADA Paratransit Services) conflict with the goals of therapy, such as confidence building?

Yes       No

Comments:

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21. Would alternative transportation (ADA Paratransit Services) interfere with the applicant's therapy or involvement?

Yes       No

Comments:

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22. Does the applicant demonstrate inappropriate social behavior (for example, is he/she aggressive or over friendly)? If Yes, please explain.

Yes       No

Comments:

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23. Comments regarding current travel and activities:

Comments:

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23. Does the individual drive a car?

Yes       No

Comments:

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25. Are there any other life skills that the individual lacks that would be an indication of his/her inability to travel on a Fixed Route Bus? If Yes, please describe.

Yes       No

Comments:

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26. Is there any additional information regarding this individual that you believe affects his/her functional ability to use regular Fixed Route Bus Service, or any special circumstances that you believe should be considered?

Comments:

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**PLACE LICENSE PHYSICIAN OFFICAL STAMP BELOW**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name & Title: \_\_\_\_\_

Current Guam Medical License No. \_\_\_\_\_

Business Address: \_\_\_\_\_  
\_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone No: \_\_\_\_\_ Fax No. \_\_\_\_\_

**ATTACHMENT C**  
**Applicant with Vision Disabilities**

**Name of Applicant:** \_\_\_\_\_

**Name of Licensed Physician:** \_\_\_\_\_

**Date Completed:** \_\_\_\_\_

1. In what capacity do you know the applicant?

\_\_\_\_\_  
\_\_\_\_\_

2. How long have you known or worked with the applicant?

\_\_\_\_\_  
\_\_\_\_\_

3. When did you last see the applicant?

\_\_\_\_\_  
\_\_\_\_\_

4. What is the formal diagnosis of the applicants eye disease or condition?

Please include a visual acuity statement which indicates

- a. The visual acuity for each eye
- b. The field vision for each eye
- c. The visual acuity with best correction for each eye

\_\_\_\_\_  
\_\_\_\_\_

5. What was the date of onset?

\_\_\_\_\_

6. What is the prognosis? Is the condition stable, degenerative, or otherwise changing?

\_\_\_\_\_  
\_\_\_\_\_

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7. Is the applicant able to walk outdoors alone?

- Sometimes       Often       Never

8. If Sometimes or Often, where can he/she travel?

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Only on his/her own property                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| To places nearby (for example, on the same block) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| To places farther away                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If Yes to places farther away, please explain: \_\_\_\_\_  
\_\_\_\_\_

9. If the applicant is able to travel outdoors alone, is he/she able to cross streets without help?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| At quiet street with very little traffic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| At traffic lights                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| At very busy intersections               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments: \_\_\_\_\_  
\_\_\_\_\_

**If the applicant is partially sighted:**

10. Is he/she able to see steps or curbs?

- Sometimes       Often       Never       N/A

Comments: \_\_\_\_\_  
\_\_\_\_\_

11. Is his/her vision affected by different lighting conditions?

- |                            |                              |                             |
|----------------------------|------------------------------|-----------------------------|
| Bright sunlight            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dimly lit or shaded places | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Night time                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments: \_\_\_\_\_  
\_\_\_\_\_

12. Is the applicants ability to travel outside alone affected by other conditions (consider in particular the impact of environment noise or the inability to distinguish traffic flow patterns)? If so, please describe.

Comments: \_\_\_\_\_  
\_\_\_\_\_

General Manager

<b>PLACE LICENSE PHYSICIAN OFFICAL STAMP BELOW</b>
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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name & Title: \_\_\_\_\_

Current Guam Medical License No. \_\_\_\_\_

Business Address: \_\_\_\_\_  
\_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone No: \_\_\_\_\_ Fax No. \_\_\_\_\_

**ATTACHMENT D**  
**Applicant with Seizure Disorders**

**Name of Applicant:** \_\_\_\_\_

**Name of Licensed Physician:** \_\_\_\_\_

**Date Completed:** \_\_\_\_\_

1. In what capacity do you know the applicant?

\_\_\_\_\_  
\_\_\_\_\_

2. How long have you known or worked with the applicant?

\_\_\_\_\_  
\_\_\_\_\_

3. When did you last see the applicant?

\_\_\_\_\_  
\_\_\_\_\_

4. Please describe what the applicant experiences during and after a seizure.

\_\_\_\_\_  
\_\_\_\_\_

5. How often do seizures occur?

\_\_\_\_\_  
\_\_\_\_\_

6. What is the prognosis?

\_\_\_\_\_  
\_\_\_\_\_

7. Are the seizures preceded by an aura?

Yes       No       Sometimes

\_\_\_\_\_  
\_\_\_\_\_

8. If Yes or Sometimes, does the applicant usually have time to prepare and make himself/herself as safe as possible?

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9. Are there certain things that will trigger the applicant's seizures?

Yes       No

Comments:

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10. If Yes, please describe these triggers.

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11. Please describe the applicant's ability to travel alone in the community. When and where can he/she safely travel?

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12. What advise or limitation on traveling alone in the community have been communicated to the applicant?

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13. Is the applicant permitted to drive?

Yes       No

Comments:

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14. Is the applicant taking any medication(s) prescribed by you or another professional?

Yes       No

Comments:

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15. If Yes, please list the type, frequency, dose and any comments about how the medication(s) may complicate the individual's independent mobility in the community?

Medication Type	Dosage	Effect on Functional Ability (if any)
General Manager		

16. If the applicant takes his/her medication compliantly, will he/she be able to travel independently in the community?

Yes       No

Comments: \_\_\_\_\_

17. Do you deem the applicant to be compliant in taking prescribed medication?

Yes       No

Comments: \_\_\_\_\_

18. Is there anything about the use of medication that would complicate the individual's use of public transportation?

Yes       No

If Yes, please explain: \_\_\_\_\_

19. Has the applicant functional ability decreased temporarily due to adjustment to medication?

Yes       No

20. If Yes, please explain and note the expected duration of the decrease in functional ability.

\_\_\_\_\_  
\_\_\_\_\_

21. Comments about the applicant's typical activities and current travel destinations.

\_\_\_\_\_  
\_\_\_\_\_

PLACE LICENSE PHYSICIAN OFFICAL STAMP BELOW

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name & Title: \_\_\_\_\_

Ethnic Origin:

Current Guam Medical License No. \_\_\_\_\_

Business Address: \_\_\_\_\_  
\_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone No: \_\_\_\_\_ Fax No. \_\_\_\_\_