交通乘车通票 (TAP)查理卡 – 医疗保健专业人员认证

医疗保健专业人员认证表格必须由获得许可或认证的医疗保健专业人员填写，并且必须在医疗保健专业人员签名后 60 天内由 MBTA 收到。

请清晰工整书写或键入并填写所有信息。

申请人名称: _____

申请人出生日期（月/日/年）: _____ 申请人电话: _____

申请人电子邮件: _____

申请人邮寄地址 _____

医疗保健专业人员姓名: _____

执照名称: _____ 专业: _____

执照编号: _____ 颁发州: _____

营业地址: _____

城市: _____ 州: _____ 邮政编码: _____

电话: _____ 电子邮件地址: _____

重要计划说明：MBTA根据申请人体验的难易程度以及由于身体、精神、智力或感官残障使用公共巴士/火车/地铁而可能需要的额外计划和工作来颁发交通乘车通票（TAP）查理卡。TAP查理卡发给具有以下残障状况的申请人：等候巴士、聆听通告、阅读视觉标志、理解和/或遵循指示、登上正确的火车、保持耐力、在人群中行动自如、步行一定距离换车等有中度/严重困难。**不会**根据申请人的收入水平**颁发TA**P查理卡。

以下部分必须由医疗保健专业人员填写：

1. **申请人有哪种残障状况?**
   请使用指南（第2页）中的类别编号: _____

   请指明诊断:

   _____

   _____

2. **如上文“重要计划说明”部分所述，搭乘MBTA出行时，该残障如何给申请人造成困难?**

   _____

   _____

3. **预计残障持续时间（请仅选择以下两个选项之一）：**
   - ☐ 短期残障（即有可能在1年内改善的情况）
   - ☐ 长期残障（即没有改善预期的情况）

4. **本人保证，就本人所知，本人提供的上述有关此MBTA TAP查理卡申请人的信息均准确无误：**

_____

医疗保健专业人员的签名 **日期**

***注意**：MBTA 保留要求查看申请人医疗保健专业人员原始签名的权利。*

医疗保健专业人员指南

请使用以下类别完成对“申请人的残疾是什么？”的回答。 医疗保健专业人员认证表格。

1. **需要使用带轮设备行动的残障人士**，例如使用轮椅、踏板车等。
2. **行动不便残障**，导致个人行走困难或不安全，可能需要也可能不需要使用腿支架、助步器、手杖、拐杖或其他移动设备。
3. **严重神经肌肉/肌肉骨骼疾病**，例如肌肉萎缩症、成骨不全症或关节炎，其功能能力在进行日常生活活动的能力中受到限制。
4. **截肢**：请说明受影响的肢体。
5. **CVA的严重影响（中风）**，包括在CVA后4个月出现影响任何两肢的功能性运动障碍或共济失调的情况。
6. **严重肺部疾病（阻塞/限制）**，影响行动能力，包括在日常生活活动中、在爬一段普通楼梯或步行100码时、稍微用力或甚至在休息时导致呼吸困难的疾病。
7. **严重的心脏病**，包括那些导致普通体力活动中度或明显受限的情况，以及在爬一段普通楼梯或步行一个或多个水平块时可能导致疲劳、心悸、呼吸困难或心绞痛的情况，只要稍微用力或即使在休息。
8. **免疫功能受损的个人**，由于艾滋病毒/艾滋病等疾病、癌症或癌症治疗、器官或骨髓移植，或慢性疾病如狼疮或类风湿性关节炎而导致。
9. **弱视**，在矫正后视力较好的眼睛为20/70或更低，但不是法定盲人。
10. **法定盲人**，在矫正后视力较好的眼睛为20/200或更低；或周边视野为10°半径或更小，无论视力如何。请注意，目前持有马萨诸塞委员会颁发的盲人身份证或其他失明证书的申请人将有资格获得MBTA盲人乘车查理卡。
11. **肾透析治疗。**
12. **失聪/听力障碍**
13. **协调性障碍**，任何两肢的功能性运动缺陷或显着降低行走能力、协调性和/或知觉的表现。
14. **智力残障。**
15. **癫痫（惊厥）。**
16. **自闭症**：请描述残障的性质和严重程度。
17. **神经性残障**，影响学习、感知和行为功能。请包括病情和病因的性质。
18. **精神残障**，患有以下长期精神疾病：
    - 包括思维、记忆、感知或辨别方向方面的实质性障碍，或
    - 严重损害判断、行为、认识现实的能力，或
    - 对满足食物、住所、衣着、财务管理和卫生保健的普通/独立生活支持需求的能力有重大影响。

如果您的医疗保健专业人员需要看英文版的C部分，请看3–4页。

TAP CHARLIECARD - HEALTH CARE PROFESSIONAL CERTIFICATION

The Health Care Professional Certification form **must be completed by a licensed or certified health care professional** and must be received by the MBTA within 60 days of the health care professional's signature.

Please print legibly or type and complete all information.

Name of applicant: _____

Applicant DOB (MM/DD/YYYY): _____ Applicant Phone: _____

Applicant Email: _____

Applicant Mailing Address: _____

Name of Health Care Professional: _____

Licensure title: _____ Specialty: _____

License number: _____ State issued: _____

Business address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email address: _____

IMPORTANT PROGRAM NOTE: The MBTA issues the Transportation Access Pass (TAP) CharlieCard based on the level of difficulty applicants experience, and the extra planning and effort that may be required, to use public buses/trains/subway due to a physical, psychiatric, intellectual, or sensory disability. The TAP CharlieCard is issued to applicants with disabilities who find it moderately/severely difficult to wait for a bus, hear announcements, read visual signs, understand and/or follow directions, board the correct train, maintain stamina, function well in crowds, walk certain distances to transfer between transit modes, etc. The TAP CharlieCard **IS NOT ISSUED** based on applicant's income level.

The following must be completed by the Health Care Professional:

1. **What is the applicant's disability?**
   Use category number(s) from Guidelines (page 2): _____

   Please specify diagnosis:

   _____

   _____

2. **How does the disability cause the applicant difficulty, as described in "Important Program Note" section above, when traveling on the MBTA?**

   _____

   _____

3. **Expected duration of disability (please select only one of the two options below):**

   ☐ Short-term disability (i.e. conditions with potential for improvement within 1 year)

   ☐ Long-term disability (i.e. conditions with no expectation of improvement)

4. **I certify that the information I have provided above about this MBTA TAP CharlieCard applicant is correct to the best of my knowledge:**

_____

Health Care Professional's Signature **Date**

Note: *The MBTA reserves the right to ask to see an original signature of the applicant's health care* professional.

Guidelines for Health Care Professionals

Please use the categories below to complete the response to "What is the applicant's disability?" of the Health Care Professional Certification form.

1. **DISABILITIES REQUIRING WHEELED MOBILITY** such as the use of a wheelchair, scooter, etc.
2. **SEMI-AMBULATORY DISABILITIES** that cause an individual to walk with difficulty or insecurity, and that may or may not require the use of leg braces, walker, cane, crutches, or other mobility device.
3. **SEVERE NEUROMUSCULAR / MUSCULOSKELETAL CONDITIONS** such as muscular dystrophy, osteogenesis imperfecta, or arthritis where functional capacity is limited in ability to perform activities of daily living.
4. **AMPUTATION OF AN EXTREMITY:** Please specify which limb(s) are affected.
5. **SEVERE EFFECTS FROM CVA (STROKE)** including conditions where there is a functional motor deficit affecting any two limbs or ataxia 4 months post-CVA.
6. **SEVERE PULMONARY CONDITIONS (obstructions/ restrictions)** that affect mobility, including those that result in dyspnea during activities of daily living; while climbing a flight of ordinary stairs or walking 100 yards; with the slightest exertion or even at rest.
7. **SEVERE CARDIAC CONDITIONS** including those that result in moderate or marked restriction in ordinary physical activity, and that may cause fatigue, palpitations, dyspnea, or angina pain while climbing a flight of ordinary stairs or walking one or more level blocks, with the slightest exertion or even at rest.
8. **IMMUNOCOMPROMISED** individuals, due to conditions such as HIV/AIDS; cancer or treatment for cancer; organ or bone marrow transplant; or chronic diseases such as lupus or rheumatoid arthritis.
9. **LOW VISION** where an individual has a visual acuity in the better eye, after correction, of 20/70 or less but is not legally blind.
10. **LEGALLY BLIND** where an individual has a visual acuity in the better eye, after correction, of 20/200 or less; or where the peripheral field is 10º radius or less, regardless of visual acuity. Please note that applicants with a current MA Commission for the Blind ID Card/Certificate or other blindness certification will be eligible for a MBTA Blind Access CharlieCard.
11. **KIDNEY DIALYSIS TREATMENT.**
12. **DEAF/HARD OF HEARING.**
13. **COORDINATION DISABILITIE**S where there is a functional motor deficit in any two limbs or manifestations that significantly reduce mobility, coordination, and/or perception.
14. **INTELLECTUAL DISABILITY.**
15. **EPILEPSY (CONVULSIVE DISORDER).**
16. **AUTISM:** Please describe nature and extent of disability.
17. **NEUROLOGICAL DISABILITIES** affecting learning, perceptual, and behavioral functioning. Please include nature of condition and etiology.
18. **PSYCHIATRIC DISABILITIES** where there is a long-term mental illness that:
    - includes a substantial disorder of thought, memory, perception, or orientation, or
    - significantly impairs judgment, behavior, capacity to recognize reality, or
    - significantly impacts ability to meet ordinary/ independent life support needs of food, shelter, clothing, management of finances, and health care.