

SMAT Application Senior/Disabled Fixed Route Discount Card

Applicant Name _____
Last First

Address _____
No. Street Unit #

City State Zip

Phone _____ Date of Birth _____

I hereby agree to release this information to SMAT for the purpose of discount fare eligibility information.

Applicant's Signature _____

I certify that the above applicant has a disability.

(Applicant's Name - Must be completed by certifying person)

The Applicant is _____ eligible for a SMAT
(permanently/temporarily)

Fixed Route discount fare. Length of disability (if temporary): _____

Type/Print Name of Certifying Person

Signature of Certifying Person

Agency - if Applicable

Address

Health Professional License

City

State

Date

**Santa Maria Area Transit
1303 Fairway Drive
Santa Maria, CA 93455**

White Copy - For Physician or Designated Agency Records

Yellow Copy - SMAT Records