



446 Novak Drive  
Martinsburg, WV 25405  
304-263-0876

**MEDICAL STATEMENT OF DISABILITY**  
**For Half-Fare Card Program**

I, \_\_\_\_\_, certify  
(Name of Physician)

that \_\_\_\_\_, is disabled.  
(Name of applicant/rider)

He / She will be considered disabled for a period of \_\_\_\_\_ months/years  
(circle one).

If this period of time is extended past one (1) calendar year, the applicant/rider is required to renew their provided card and have a signed physician statement every calendar year.

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Medical Professional Signature: \_\_\_\_\_

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

Applicant Signature: \_\_\_\_\_

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