446 Novak Drive
Martinsburg, WV 25401
304-263-0876

MEDICAL STATEMENT OF DISABILITY
For Half Fare Card Program

I, _____, certify that, _____, is disabled. He or She will be considered disabled for a period of _____.
If this period of time is extended past one year you need to renew your card and have a signed physician statement every year.

Medical Professional Signature: _____ Date: _____

Applicant Signature: _____ Date: _____