MERTHYR TYDFIL COUNTY BOROUGH COUNCIL

DISABLED BUS PASS APPLICATION FORM

Please complete this form is you cannot travel by bus without someone else's help OR you are under 60 years of age AND have one or more of the following disabilities – profoundly or severely deaf, without speech, walk with difficulty, without the use of arms, a learning disability or a medical condition that would disqualify you from driving.

Title (✓) Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ Gender (M/F) ☐

Please complete in BLOCK CAPITALS

Surname			
First Name(s)			
Address			
Town/Village			
Post Code		Tel. No.	
Date of Birth		Current Pass No. if available	

I declare that

(a) ☐ I am registered blind/partially sighted. Registration Number :…….

(b) ☐ I have a current Disabled Persons Car Badge. Badge Number:……..

(c) ☐ I receive Disability Living Allowance Mobility Component at the higher rate
Please bring your letter of confirmation of high rate mobility
National Insurance Number :……..

(d) ☐ I am profoundly or severely deaf

(e) ☐ I am without speech

(f) ☐ I have a disability, or have suffered an injury, which has a substantial and long term adverse effect on my ability to walk

(g) ☐ I do not have arms or have long-term loss of the use of both arms

(h) ☐ I have a learning disability

(i) ☐ I would be refused a licence to drive a motor vehicle for medical reasons, other than on the grounds of persistent misuse of drugs or alcohol

I declare that

(j) ☐ I am unable to travel by bus without the assistance of another person

If medical evidence is considered necessary to support my application, I authorise the County Borough Council to obtain it. Please complete your doctors details on the reverse of this form.

Data Protection Act 1998: Information provided by you will be held and automatically processed on a computer system. The council will take all reasonable precautions to ensure confidentiality to comply with the principles contained within the Act. The information may be compared with other personal data held by the Council in order to aid prevention of fraud in the administration of public funds and may be used for cross Authority comparison purposes. I confirm that I hereby give consent to use the information I have provided for the above purpose

Signature: …… Date of Application: ……..

Doctor's Details :

Please complete in BLOCK CAPITALS

Doctors Name	
Address	
Postcode	

This form MUST be returned to Service Support, Civic Centre, Castle Street, Merthyr Tydfil, CF47 8AN.

FOR OFFICE USE ONLY

I certify that : ……..

Is eligible for a Concessionary Bus Pass under Category : …….. Yes | No

Is eligible for a Concessionary Bus Pass plus Companion : ……. Yes | No

Is not eligible for a bus Pass because : ……

…….

Signed (for Corporate Chief Officer, Social Services) : …….

Date : ……

OFFICE STAMP