MOBILITY PROGRAM

PHYSICIAN'S ASSESSMENT FORM

The undersigned confirms that the patient named below:

1. Requires vehicle modification to enable him/her to drive. ☐
2. Requires vehicle modification to allow convenient access to enable him/her to transport a person with a disability. ☐
3. Experiences a minimum 30 dB hearing loss in any frequency range and would therefore benefit from having an assistive alerting device installed in his/her new GM vehicle. ☐

Physician's Name (Printed) ______________________

Physician's Signature ______________________

Date ______________________

Patient's Name (Printed) ______________________

Patient's Name Signature ______________________

Date ______________________

Please Note:

- Please attach a copy of the physician's letterhead or copy this information on your physician's letterhead.
- As an alternative, please attach a prescription form to this document for confirmation of the physician's formal practice address and contact numbers.