DFHV
Government of the District of Columbia
Department of For-Hire Vehicles

WE ARE WASHINGTON DC
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

# Transport DC Dialysis Exemption Form

## PART A: TO BE COMPLETED BY CUSTOMER

| Transport DC Customer Info: | | | |
|---|---|---|---|
| First Name | | | |
| Last Name | | | |
| MetroAccess ID | | | |
| Home Address | | | |
| City/State/Zip | | | |
| Primary Phone | | Cell Phone | |
| Email | | | |
| **Primary Dialysis Center Info:** | | | |
| Name | | | |
| Street Address | | | |
| Main Phone | | Email (if available) | |
| Website | | | |
| Email | | | |
| **Secondary (or possible alternative) Dialysis Center Info:** | | | |
| First Name | | | |
| Street Address | | | |
| Main Phone | | Email (if available) | |
| Website/Email | | | |

## Medical Release – MUST BE SIGNED BY CUSTOMER

I, ____________________________________________authorize the healthcare provider completing this application to release to the DC Department of For-Hire Vehicles the protected health information regarding my disability that necessary in order to verify my eligibility for dialysis transportation, as indicated on Part B of this application. I also authorize the release of further information should it be necessary for this application for a period of sixty (60) days from the date of my signature on Part A of this application.

Transport DC Customer Signature______________________________________________
Date:_________________________

**Part B: This section must be completed by your health care provider and must be signed by one of the following qualified medical professionals: physician, physician's assistant or certified nurse practitioner.**

1. Name of Health Care Provider: *(Please print)*

___

2. Phone:

___

3. License Number/State Issued:

___

4. Street Address & Suite Number:

___

5. City, State, Zip:

___

6. Specialization:

___

7. Does this patient require dialysis treatment? ___ Yes __ No
8. If yes, how many times a week is dialysis required for this patient? ________
9. Written Diagnosis(es) and ICD-9CM and/or DSM Code(s) (why the patient requires dialysis):

___

10. Please indicate how long do you anticipate that the patient will require dialysis treatment?

___

I certify that I have completed the questions in Part B and that the information provided is correct.

***Original Signature of Physician/Healthcare Provider*** (Note: Must be original hand signature in blue ink, not signature stamp)

______________________________________________________________________________

***Date*:**

False certification may be reported to the licensing agency under District of Columbia Code Annotated, Section 2-3305.15, Code of Virginia 54. 1-2915, or Maryland Health Occupations Code Annotated 14-404 or appropriate code for state of license. DFHV reserves the right to: (1) verify the validity of the license of the health care provider providing the certification, (2) make the final determination on an applicant's eligibility for a dialysis transportation exemption under Transport DC and (3) retain a copy of this application form.

**Note to the Transport DC Customer: This form is subject to verification for eligibility for dialysis transportation under the Transport DC Program. The form can be submitted in the following ways:**

By Mail: Transport DC
Department of For Hire Vehicles
2235 Shannon Place SE Suite 3001
Washington, DC 20020

By Email: transportDC@dc.gov