

**Town of West Hartford Dial-A-Ride**  
Fee Waiver Form for a Medically Necessary DAR Companion Rider

**Dial-A-Ride Passenger**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Dial-A-Ride Companion Rider**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

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**Medical Provider Certification**

Medical Provider's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

I, \_\_\_\_\_, hereby certify that the Dial-A-Ride passenger named above has a medical condition and/or a disability which prevents them from being able to safely negotiate a Dial-A-Ride service bus without the benefit of a companion to ensure their safety.

\_\_\_\_\_  
Medical Provider's Signature and Title

\_\_\_\_\_  
Date

Mail or fax completed form to:  
**West Hartford Dial-A-Ride**  
**50 South Main Street, Rm. 306**  
**West Hartford, CT 06107**  
**Fax: 860-561-7577**