APPLICATION FOR MODIFICATION OF FULL-TIME DRIVING REQUIREMENT DUE TO TEMPORARY MEDICAL CONDITION (Version 5.1.20)

Last Name First Name	Last Four Digits of California Driver License
Address	Main Contact Phone
City, State Zip	Email

By completing and signing this form, you are requesting a modification of the Full-Time Driving Requirement for your San Francisco **Post-K** taxi medallion based on a qualifying medical condition in accordance with the regulations, policies and procedures of SFMTA. You may be required to provide additional documentation in support of your request. Modifications to the Full-Time Driving Requirement may only be granted due to a temporary medical condition. Modifications are granted pursuant to SFMTA Board Resolution 09-138 (August 4, 2009).

1. **Medallion Number:** _____

2. **Modifications may only be granted Due to a Temporary Medical Condition**

   Is this your first time applying for a modification? ☐ Yes ☐ No

   If no, then when did you first apply (date)? _____

   What type of modification are you requesting?

   ☐ Reduction of Driving Hours
   ☐ Suspension of All Driving

   Please describe the requested modification:

3. **Health Care Provider**

Please provide us with the name of your health care provider(s) who can assist in this request. If you have additional providers who also have information on this matter, please list that information below your signature line:

Name:	
Address:	
Phone:	
Specialty:	

Name:	
Address:	
Phone:	
Specialty:	

Please state the expected duration of your temporary medical condition: _____

Please note that no modification of the Full-Time Driving Requirement may be granted for permanent conditions.

I hereby certify the foregoing to be true and correct. Granting of a modification does not signify approval of any future modification request for any other permit issued by the SFMTA or any other department within the City and County of San Francisco.

Signature: _____ Date: _____

HEALTH CARE PROVIDER CERTIFICATION

Physician's Name	
Physician's Address	City, State Zip
Physician's Phone	Physician's Email
Physician's License Number	

The following individual has identified him/herself as your patient:

_____ _____

Last First Last 4 Digits of CDL

Date of your last examination of this individual:

Please describe the temporary health condition that requires a modification of the Full-Time Driving Requirement:

Please describe the modification to the Full-Time Driving Requirement, which is defined as 800 hours per calendar year:

Please state the expected duration of this temporary medical condition:

I, the undersigned health care provider, certify that the information provided concerning_____is complete and accurate to the best of my knowledge.

By signing this form, I agree to respond in a timely manner, to SFMTA's questions as to the basis for the statements that I made on this form. I understand that my cooperation is necessary for the SFMTA to make an accurate determination on my patient's request for a modification of the Full-Time Driving Requirement for a San Francisco Post-K taxi medallion holder.

_____ _____

Health Care Provider's Signature *Date*

_____

Print Name