Transit Authority of the City of Omaha
2222 Cuming Street
Omaha, NE 68102
402.341.0800
TDD: 402.341.0807
Email: COVID@ometro.com

PERSON WITH A DISABILITY REQUEST for REASONABLE MODIFICATION MEDICAL CERTIFICATION REQUEST

SIDE 1: REQUESTOR INFORMATION

1. Requestor's Name: _____
LAST FIRST MIDDLE INITIAL

2. Phone Number: ( )_____ **3. Email:** _____

4. Address:_____

City: _____ **State:** _____ **Zip Code:** _____

5. Birth Date: _____ **6. Date of Request:** _____
MONTH / DAY / YEAR DATE OF SUBMISSION

7. REQUESTOR'S DECLARATION & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I declare, that the information provided is true and accurate to the best of my knowledge; and I acknowledge that providing false information on this request may invalidate my request for a reasonable modification.

I also authorize my Heath Care Professional to
release medical information necessary to process my Reasonable Modification
Not to Wear a Mask due to COVID-19.

I acknowledge, that the affixed Health Care Professional Certification (HCPC) Date is valid for only 30 calendar days and this request will be rejected if submitted after 30 calendar days of the HCPC date.

X_____ _____
REQUESTOR'S SIGNATURE Date

X_____ _____
PARENT/GUARDIAN'S SIGNATURE IF APPLICANT IS UNDER 19 Date

FOR OFFICIAL USE ONLY - DO NOT WRITE IN THIS BLOCK

Health Care Professional License Verification: License Status: _____ Expiration Date: _____

☐ Request Processed: ☐ Permanent ☐ Temporary: _____months HCPC Date: _____

☐ No Mask/Face Shield RM Card

☐ Request Denied: Reason: _____

Signature: _____ Date: _____
(DESIGNEE)

SIDE 2: CERTIFICATION BY LICENSED HEALTH CARE PROFESSIONAL:

A Health Care Professional includes a licensed social worker, occupational therapist, physiatrist, physical therapist, rehabilitation specialist, medical physician, registered nurse, psychologist, mental health counselor, speech pathologist, or similar professional, duly licensed to practice in the State of Nebraska.

8a. I certify that (Requestor's Name) _____qualifies for a reasonable modification as a Person with a Disability based on <u>one</u> of the following categories:

☐ The Requestor has a physical or mental disability that substantially limits a major life activity; or
☐ The Requestor has a record of a physical or mental disability that substantially limits a major life activity.

8b. State the nature of the physical or mental disability that affects his/her ability to wear a mask or facial covering due to COVID-19:

_____
_____
_____
_____
_____
_____

8c. Provide your best estimate of the duration of the medical condition: _____

8d. <u>Health Care Professional Certification</u>. As a Health Care Professional duly licensed in the State of Nebraska, I understand that falsely certifying that the Requestor is qualified for the purposes of this application form are grounds for licensing sanctions enforcement under Title 172 NAC 5, and Nebr. Rev. Stat. §71-168 to 71-168.02.

Name: _____ Phone No: ( ) _____

Agency: _____ License No: _____

Address: _____License Expiration Date: _____

City: _____State: _____ Zip Code: _____

Signature: _____ *Date: _____

*The expiration date of METRO Reasonable Modification from Mask Card is based on the Health Care Professional Certification date and the estimated duration of the Requestor's medical condition.

ATTENTION: METRO must have the required medical information for not wearing a mask and the Requestor must have a METRO Reasonable Modification from Mask Card before the Requestor may ride.

REQUEST FOR REASONABLE MODIFICATION INSTRUCTION SHEET

SIDE 1: REQUESTOR INSTRUCTIONS

1. **Requestor's Name:** Print your name (Last Name, First Name, Middle Initial).
2. **Phone Number:** Print your telephone number. If you do not have a telephone number, write "NONE."
3. **Email is optional.** METRO will use it ONLY to contact you for the *Reasonable Modification from Mask Card*.
4. **Address:** Print your address.
5. **Birth Date:** Print the month, day, year.
6. **Date of Application:** Input the date that you submit the application in-person (Submit your application within 30 calendar days of the Health Care Professional Certification date).
7. **Declaration and Authorization to Release Medical Information:** Signature to verify the information you provided is correct; authorize your health care professional to complete Side 2 and release medical information (the medical information provided will only be used to determine eligibility for a *Reasonable Modification from Mask Card*); and acknowledge that this application will be rejected if submitted after 30 calendar days of the Health Care Professional Certification date.

SIDE 2: LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION INSTRUCTIONS

8a. Certify Requestor's disability and need for a reasonable modification by checking the appropriate category box.

8b. State the nature of the physical or mental disability that affects his/her ability to wear a mask or facial covering due to COVID-19.

8c. Provide an estimate of the duration of the medical condition.

PERSON WITH A DISABILITY REQUEST FOR REASONABLE MODIFICATION FROM THE FEDERAL MASK LAW (*See Federal Register, Vol. 86, No. 21*), SHALL BE SUBMITTED TO:

METRO
ATTN: MASK EXCEPTION
2222 Cuming Street
Omaha, NE 68102

1. Only completed and signed requests are accepted for processing.
   (Incomplete requests will NOT be processed. Complete all lines with true/accurate information.)
2. An official, valid picture identification (ID) is required for proof of identity (Acceptable forms of ID include driver's license, state ID, passport, other government agencies ID).
3. The card expiration date is based on the Health Care Professional Certification date.
4. METRO Administrative Hours: Monday – Friday, 8:30 a.m. – 4:00 p.m. (Closed on Holidays)
   Phone: 402-341-0800
   TDD: 402-341-0807
   Fax: 402-939-6814
   Email: COVID@ometro.com

Transit Authority of the City of Omaha
2222 Cuming Street
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Email: COVID@ometro.com

Request for Approval of a Reasonable Modification from Mask Requirement

Requestor's Name: _____

Telephone Number: _____ Email: _____

Mailing address: _____
Street Address City State Zip

Reason for Request:
(Please provide the reason for requesting for a reasonable modification from wearing a mask. Provide general information as to why you are not medically able to wear a mask.)

_____
_____
_____
_____

Reasonable Modification from Wearing a Mask:
(Please specify the reasonable modification from existing policy that you are requesting.)

_____
_____
_____
_____

The above is true and accurate to the best of my knowledge.
Requestor's Signature: _____ **Date:** _____

THIS FORM MUST BE SUBMITTED WITH THE PERSON WITH A DISABILITY REQUEST for REASONABLE MODIFICATION MEDICAL CERTIFICATION REQUEST.

If request is not submitted Requestor, form may be completed by a contact person:

Name: _____ Phone or email: _____

Relationship to requestor: _____

Signature: _____ Date: _____

INTERNAL USE ONLY: Date Received: _____

Date Interactive Communication Process initiated with Requestor: _____

RM Approved: _____ RM Approved, but different: _____

Specific Reasonable Modification Approved: _____

RM Disapproved and why: _____

METRO authorized designee:

Signature: _____ **Date:** _____

If you need assistance with completing this form, please contact METRO Customer Service at (402)341-0800; TDD: 402-341-0807.