Form 3A

Blind or Partially Sighted Disability Evidence Form

West Berkshire Council
Concessionary Fares Team
Council Offices, Market Street,
Newbury, RG14 5LD
Telephone No: 01635 519394
email: transport@westberks.gov.uk
www.westberks.gov.uk/concessionaryfares

Privacy Notice: To find out how we use the data you give us on this form visit www.westberks.gov.uk/pnconcessionaryfares

To be filled in by applicant

Declaration of authority. I authorise the consultant / specialist (shown below) to disclose to West Berkshire Council the information requested in this form. Please PRINT details.

Name | Date of birth

Address | Tel. no.

Email

Postcode

Signed | Date

To be filled in by a qualified medical practitioner

Dear Consultant or Specialist,

The person mentioned above has applied to us for a travel concession on the basis of being **partially sighted or blind.**

The Transport Act 2000 defines Blind as “having a high degree of vision loss i.e. seeing much less than is normal or perhaps nothing at all” and Partially Sighted as “a person who can see more than someone who is blind, but less than a fully sighted person”. This is clarified in more detail in the options below.

Please tick the box(es) that apply to this person.

- ☐ They cannot see (with glasses, if worn) the top letter of the eye test chart at a distance of 3 metres or less.
- ☐ They can read the top letter of an eye test chart at 3 metres, but not at 6 metres and their field of vision is also severely restricted.
- ☐ They have a full field of vision but can only read the top letter of the eye test chart at a distance of 6 metres or less (with glasses, if worn).
- ☐ They can read the top 3 lines of an eye test chart at 6 metres (with glasses, if worn), but their field of vision is either moderately or severely restricted.

OR

- ☐ I am unable to confirm that any of the above options apply to this person.

☐ **Please tick this box** if this is a permanent disability, which has a substantial effect on the above person’s ability to carry out normal day-to-day activities.

Name

Position

Address

GMC No. | Tel:

Signed | Date

On completion please return the form to the applicant

OFFICIAL CLINIC / HOSPITAL STAMP HERE

Once completed, the applicant should submit this Evidence Form, along with the Concessionary Bus Pass Application Form, proof of residence, and date of birth and photograph.