



Severe Walking Disability Evidence Form

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	<input type="text"/>	Date of birth	<input type="text"/>
Address	<input type="text"/>	Tel. no.	<input type="text"/>
	<input type="text"/>	Email	<input type="text"/>
	Postcode	<input type="text"/>	
Signed	<input type="text"/>	Date	<input type="text"/>

To be filled in by a qualified medical practitioner

Dear Consultant or Specialist,

The person mentioned above has applied for a travel concession on the basis of having a disability which has a **substantial and long-term adverse effect on their ability to walk**.

The Transport Act 2000 defines this as "having a physical disability, or has suffered an injury, which has a substantial and long-term adverse effect on their ability to walk". This is clarified in more detail in the options below.

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

- They are unable to walk a single step or their only way to get about is to swing through crutches.
- (With or without an aid) they cannot walk for distances over 64 metres without severe discomfort at the time or later as a result of walking the 64 metres.
- They cannot walk 100 metres within 5 minutes
- They are unable to walk very far and the effort required to walk is likely to lead to a serious deterioration in their health, needing medical intervention for them to recover.
- The effort to walk would constitute a danger to their life

OR they are ineligible if

- This is currently not a permanent disability, and they have suffered from this disability/injury for less than 12 months.
- 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	<input type="text"/>		
Position	<input type="text"/>		
Address	<input type="text"/>		
GMC No.	<input type="text"/>	Tel:	<input type="text"/>
Signed	<input type="text"/>	Date	<input type="text"/>

**OFFICIAL
 CLINIC / HOSPITAL
 STAMP HERE**

On completion please return the form to the applicant

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.

