Form 3D

Severe Walking 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 https://info.westberks.gov.uk/privacynotices

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 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

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.