Chesapeake Bay Bridge Tunnel Ticket Application

Date: _____

Patient Name: _____ DOB:_____

Phone #: _____ SSN: _____

Address: _____

1. Where do you go to the doctor for routine visits? Please circle one:
   ESRHS – Eastern Shore Rural Health
   Perdue Wellness Center Riverside Physicians
   Other: _____
2. Are you currently on ESRHS' sliding fee scale? ____ Yes ____ No
   Expiration Date: _____
3. What type of insurance do you have? _____
4. Are you a veteran? ____ Yes ____ No

List every member of your household including yourself:

Name	Date of Birth	Relationship	Source of Income	Amount before taxes

I give the following individual(s) permission to pick up passes for me:

_____ _____ _____

I certify that the information given is true and complete to the best of my knowledge and belief. I understand that my Primary Care Provider's Office and/or Eastern Shore Rural Health System, Inc. may verify my income in order to determine my eligibility for Chesapeake Bay Bridge Tunnel Tickets.

_____ _____

Date Applicant's Signature

This information needs to be updated on a yearly basis.

Internal use only:

Notes:

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