MEDICAL CERTIFICATION FORM

(To be completed by attending physician)

I certify that _____ is my patient and is incapable of self-sustaining employment due to the behavioral and/or physical handicap described below.

1. FUNCTIONAL CAPACITY

PHYSICAL	COGNITIVE
❒ Unable to transfer	❒ Unable to make basic decisions
❒ Confined to room	❒ Can make needs known only
❒ Mobile with adaptive device(s)	❒ Can manage medications
❒ Ambulatory	❒ Can manage personal finances
❒ Able to sit at desk	❒ Able to complete tasks with minimal direction
❒ Can lift 10-20 lbs only	COMMUNICATION
❒ No limitations	❒ Unable to adequately comprehend or express needs
	❒ Communicates with adaptive device(s)
	❒ Can communicate

❒ Other limitation(s): _____

_____

_____

2. Diagnosis: _____
3. Date of Onset: _____ Permanent ❒

   Prognosis/expected duration: _____

   Other: _____
4. Dates & reasons for hospitalization, if any, within the past 24 months:

   _____

   _____
5. Current living arrangements: _____

   _____
6. Potential for independent living: _____

   _____

   _____

Physician signature: _____

Physician's printed name: _____

Address: _____

Phone/Contact: _____

Records enclosed: ❒ Yes ❒ No