Patient Name_____ Medical Record No_____

PHYSICIAN CERTIFICATIONS RELATED TO MEDICAL CONDITION, DECISION MAKING, AND TREATMENT LIMITATIONS

PART 1: IDENTIFYING INFORMATION

-*Patient*: I am certifying information about_____

-*Certifying practitioner (check all that apply)*: I am (X)the attending physician/( )the medical director or another certifying practitioner/ ( )a neurologist, neurosurgeon, or other physician with special expertise in evaluating cognitive functioning required for diagnosing a persistent vegetative state.

-*Time frame*: (X) The following certifications are made within 2 hours of examining the individual.

PART 2: CERTIFICATIONS

a) *Certification of General Status*

Based on my evaluation, I hereby certify that this individual (*select one, if applicable*):

☐ Is in an **end-stage condition** based on *all of the following:*
-has an advanced, progressive, irreversible condition caused by injury, disease, or illness AND
-has severe and permanent deterioration indicated by incompetency and complete physical dependency AND
-to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

☐ is in a **persistent vegetative state** based on *all of the following:*
-injury, disease, or illness have resulted in a loss of consciousness AND
-the individual exhibits no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflex activity of muscles and nerves for low level conditioned response AND
-after passage of a medically appropriate period of time, it has been or can be determined, to a reasonable degree of medical certainty that there can be no recovery.

☐ is in a **terminal condition** caused by injury, disease, or illness based on *both of the following*:
-to a reasonable degree of medical certainty, death is imminent AND
-despite the application of life-sustaining treatments, there can be no recovery.

b) *Certification Regarding Medical Ineffectiveness*

☐ I hereby certify that, to a reasonable degree of medical certainty, the following treatment(s), which under generally accepted medical practices are life-sustaining in nature, would not prevent or reduce the deterioration of the individual's health or prevent his or her impending death (list treatments):
( ) CPR ( ) Mechanical Ventilation or Respiration ( ) Hospitalization ( ) Antibiotics ( ) Blood Products
( ) Medical Tests ( ) Artificial Hydration ( ) Artificial Nutrition ( )Other_____

I have informed the following individual(s) of my determination that the treatments designated above would be medically ineffective: ( ) the affected individual ( ) the individual's Agent, guardian, or surrogate.

c) *Certification Regarding Decision Making Capacity*

1) ***Level of decision making* capacity**. Based on my evaluation, I hereby certify that this individual (*check one*):
(X) has adequate decision making capacity (including decisions about life-sustaining treatments)
( ) lacks adequate decision making capacity (including decisions about life-sustaining treatments)

2) ***Diagnosis or reason for incapacity:*** ☐ Dementia ☐ Stroke/CVA ☐ Brain injury ☐ Delirium ☐ Other_____

Signed_____ Cramm _____, M.D. Date 02/15/2025