|  |  |  |
| --- | --- | --- |
| **PARTICIPANT’S NAME** | **MPID** | **DATE OF BIRTH** |
| {stdMbrFullNameInProperCase} | {stdMbrParticipantMPID} | {stdMbrDateOfBirth} |

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| --- | --- | --- | --- | --- |
| **PHYSICIAN’S INFORMATION** | | | | |
| **Name (please print)** | | | | |
|  | | | | |
| **Specialty** | | | **Medical License #** | |
|  | | |  | |
| **Address** | | **City** | **State** | **Zip** |
|  | |  |  |  |
| **Phone** | **Fax** | **Email** | | |
|  |  |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PHYSICIAN’S FINDINGS** | | | | | | | | |
| Diagnosis: | |  | | | | | |  |
| Date of initial disability: | | |  | | Date Participant was last examined by you: | |  |  |
| Present condition (Clinical Status – Include initial evaluation and current status of patient): | | | | | | |  |  |
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|  |  | | | | | | |  |
| Please describe Participant’s job (To be completed by Participant): | | | | | |  | |  |
|  |  | | | | | | |  |
|  |  | | | | | | |  |
| Is the patient currently diagnosed as terminally ill with a life expectancy of fewer than two years? | | | | | | | | |
| Yes No | | | |  | | | |  |
| Does the terminal illness prevent the Participant from engaging in gainful employment? | | | | | | | | |
| Yes No | | | |  | | | |  |
|  | | | | | | | | |

**PHYSICIAN’S CERTIFICATION**

I, the undersigned, a practicing licensed physician, hereby certify under penalty of perjury, that my answers to the foregoing questions are complete and true to the best of my knowledge, information and belief.

Physician’s Signature Date