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

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **PHYSICIAN’S FINDINGS** | | | | | | | |
| 1. | Does the patient lack the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a decision for him/herself, the ability to reach an informed decision, and the ability to communicate such decisions? Yes No | | | | | |  |
| 2. | The nature of the impairment (disability) is: Physical Mental | | | | | |  |
| 3. | Diagnosis: |  | | | | |  |
|  |  | | | | | |  |
|  | Date of onset: | |  | Date Participant was last examined by you: | |  |  |
|  |  | | | | | |  |
| 4. | Is the impairment considered total and permanent? Yes No | | | | | |  |
|  | If “No”, what is the anticipated duration of the impairment? | | | |  | |  |
|  |  | | | | | |  |
|  | | | | | | | |

**PHYSICIAN’S CERTIFICATION**

I, the undersigned, a practicing licensed physician or therapist, 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