RE-CERTIFICATION OF DISABILITY

Applicant's Name _____
First Middle Last

Age _____

Male _____ Female _____

Diagnosis/Analysis _____

a) Applicant's symptoms _____
_____

b) Objective findings _____
_____

Is disability referenced in attached certification continuing as total and permanent as of this date? Yes _____ No _____

NOTE: Definition of disabled – impaired, incapacitated, or unable, as a result of illness, disease disorder, other pathological condition or injury, to discharge any normal physical or mental function, whether permanently or temporarily and whether totally or partially, and requiring therapeutic, corrective, rehabilitative or other prescribed treatment or use of prescribed medication or device or devices.

Date of last examination or treatment: _____

I affirm that I am a _____
e.g. Physician, Podiatrist, Chiropractor, Dentist

Licensed in the State of _____ License No. _____

Doctor's Signature _____

Doctor's Name (Please Print) _____

Office Address _____
No. Street Town State Zip

Telephone No. _____

Date _____