Certification for Severe Disability

Date of Assessment: _____

I, _____, have determined that _____, is
(Doctor's name) *(Patient's name)*

diagnosed with _____.
(Medical Condition)

This is a severe, chronic disability which is attributable to mental or physical impairment(s), or a combination of mental and physical impairments. This condition is likely to continue indefinitely and results in substantial functional limitation in <u>three</u> or more of the following areas of major life activity:

Check all that apply:

____ Self-care
____ Receptive and expressive language
____ Learning
____ Mobility
____ Self-direction
____ Capacity for independent living
____ Economic self-sufficiency

Additional information as needed:

_____

_____

_____

_____ _____
Signature of Doctor/Medical Professional Date

_____ _____
Doctor/Medical Professional Name, Printed License Number