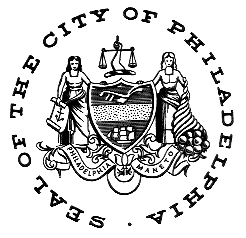
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**OFFICE OF ECONOMIC OPPORTUNITY (OEO)**

**Physician’s Certification Disability Form**

**(*Must be completed by Physician*)**

Full Name of Individual with Disability: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Disability: 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Functional limitations: (Check all that apply and attach a narrative description on medical personnel’s letterhead)

Mobility  Eyesight

Speech/Communication  Manual Tasks

Self-Care

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Patient | ICD-CM Diagnosis Code(s) | Date of onset of disability (MM/DD/YY)  Continuous Functional Limitation(s)  Yes  No  **­­­­­­­­­­­­­­­** | Date patient first consulted you (MM/DD/YY) |
| Please type and attach a detailed description of any substantial and continuing functional limitations resulting from the diagnosed disability. This should include the probable duration of the limitations and the prognosis for recovery. The description must be signed by the certifying physician on their letterhead and include the professional medical license number. | | | |
| I certify that all of the statements made above and any attached information is true and correct and understand that submitting and/or attesting to any false information subjects me to the appropriate penal code Pennsylvania, including without limitation 18 Pa. C.S.4904. | | | |
| Signature of Certifying Physician Date Telephone Number  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Professional Medical License Number | | | |

***OEO Physician’s Certificate 3/9/18***