FLORIDA

PHYSICIAN'S CERTIFICATION OF TOTAL AND PERMANENT DISABILITY

INSTRUCTIONS

I, _____ 1 _____, a physician licensed pursuant to Chapter 458 or Chapter 459,
Physician's name
Florida Statutes, hereby certify that ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____ 2 _____
Name of totally and permanently disabled person

Social Security Number* ___ 3 ___ , is totally and permanently disabled as of January 1, ____ 4 ____ due to the following mental or physical condition(s):

☐ Quadriplegia ☐ Paraplegia ☐ Hemiplegia ☐ Legal blindness

5 ☐ Other total and permanent disability requiring use of a wheelchair for mobility

☐ Check here if patient is totally or permanently disabled but does not require a wheelchair for mobility.

It is my professional belief the above condition(s) render ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

_____ 6 _____ totally and permanently disabled and the foregoing statements are true, correct, and complete to the best of my knowledge and professional belief.

_____ 7 _____ _____ 8 _____
Signature Date

Address: (print) 9

_____ _____ _____ _____
Street City State Zip

Florida Board of Medicine or Osteopathic Medicine license number _____ 10 _____

Issued on _____ 11 _____

Please check that the following information was filled out by your doctor before leaving his/her office:	Por favor verifique que la siguiente información fue llenada por su doctor antes de salir de su oficina:
1. Name of a licensed FL physician 2. Applicant's name (patient) 3. SSN of Applicant (patient) 4. Year when disability started 5. The physician needs to choose what applies to the applicant (patient). See below: a. Quadriplegia b. Paraplegia c. Hemiplegia d. Legal blindness e. Other total and permanent disability requiring use of a wheelchair for mobility f. Check here if patient is totally or permanently disabled but does not require a wheelchair for mobility 6. Applicant's name (patient) 7. Physician's signature 8. Date when physician signed this form 9. Address (physician's current medical practice address) 10. License # (physician must have a ME or OS license) 11. Date when license was issued	1. Nombre del doctor autorizado por el estado de la Florida 2. Nombre del solicitante (paciente) 3. Número de Seguro Social del solicitante (paciente) 4. Año en el cual comenzó su discapacidad 5. El doctor necesita escoger lo que aplica al solicitante (paciente). Vea abajo: a. Quadriplegia b. Paraplegia c. Hemiplegia d. Ceguera legal e. Otra discapacidad total y permanente que requiera silla de ruedas para mobilizarse f. Marque aquí si el paciente es totalmente y permanentemente discapacitado pero no necesita silla de ruedas para mobilizarse 6. Nombre del solicitante (paciente) 7. Firma del doctor 8. Fecha cuando el doctor firmó esta forma 9. Dirección (dirección actual de la oficina donde el doctor practica medicina) 10. # de Licencia (el doctor deber tener una licencia de ME or OS) 11. Fecha de cuando la licencia fue emitida