

CERTIFICATION BY PHYSICIAN

I am licensed to practice medicine in the state of _____.

I have been treating _____ for the following:

Patient's Name

List nature of illness in sufficient detail including the stage of illness, etc., or attach documentation necessary to support this certification.

In my professional opinion, _____ is terminally ill and has a life expectancy

Patient's Name

of less than one year.

PHYSICIAN'S SIGNATURE	DATE
PHYSICIAN'S NAME	LICENSE NUMBER