ADA Compliant
R: 8/2021

FLORIDA DEPARTMENT OF REVENUE

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