

**PHYSICIAN'S STATEMENT**

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_ Zip code \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_  
(area code)

Physician's Fax Number \_\_\_\_\_  
(area code)

I here by certify that the physical condition of applicant:  
\_\_\_\_\_ requires the **permanent** use of:

(Circle One)

1. Wheelchair 2. Crutches 3. Tripod Cane 4. Walker

Please provide a brief description of the applicant's disability.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_

Physician's Registration Number \_\_\_\_\_

Date: \_\_\_\_\_