DEPARTMENT OF PUBLIC WELFARE

CERTIFICATION OF TERMINAL ILLNESS

1 RECIPIENT NUMBER

2 RECIPIENT NAME ("PATIENT")

I hereby certify that the above named Patient has been diagnosed as having the following disorder:

3 WRITTEN DIAGNOSIS

4 ICD-9-CM DIAGNOSIS CODE

and that it is my professional opinion that the Patient has a life expectancy of six (6) months or less.

☐ Initial Certification ☐ Recertification

5 SIGNATURE OF PATIENT'S ATTENDING PHYSICIAN — 6 DATE

7 SIGNATURE OF MEDICAL DIRECTOR — 8 DATE

9 SIGNATURE OF INTERDISCIPLINARY TEAM PHYSICIAN — 10 DATE

MA 372 5/06

HOSPICE