



Employee Name: \_\_\_\_\_  
Last First Middle Initial

Employee Zpid #: \_\_\_\_\_

Dependent Name: \_\_\_\_\_  
Last First Middle Initial

Dependent Birthdate: \_\_\_\_\_

**PHYSICIAN'S CERTIFICATION**

In my judgement, \_\_\_\_\_ is  
Dependent Name

\_\_\_\_\_ physically disabled \_\_\_\_\_ mentally disabled (check one)

to such a degree as to be incapable of any self-sustaining occupation. His/her condition, which  
has been diagnosed as \_\_\_\_\_,  
and the resulting incapacity have existed since \_\_\_\_\_.

This disability is  Permanent  Temporary

If temporary, the prognosis for improvement to enable a self-sustaining occupation is:

\_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Business address \_\_\_\_\_