

**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/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

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