PHYSICIAN'S CERTIFICATION OF DISABILITY

This form is to be executed by a physician licensed by the state of New York.

Nature of Disability _____

What artificial aid required _____

I, _____ Hereby certify that I have examined _____
Name of Applicant

and find Him\Her to have a permanent disability.

DATE: _____

_____
Signature of Physician

Return this form with application

_____
Street Address

_____
Post Office Zip