PHYSICIAN CERTIFICATION OF TERMINAL ILLNESS

CERTIFICATION STATEMENT (FIRST 90-DAY PERIOD) _____
Dates of Service

WE (OR I) CERTIFY THAT _____IS TERMINALLY ILL WITH A LIFE EXPECTANCY OF SIX (6) MONTHS OR LESS BASED ON THE EXPECTED COURSE OF THE DISEASE.

_____ _____
Certification Date Angel Rodriguez, MD, Medical Director Date

_____
Attending Physician Date

VERBAL CERTIFICATION OF TERMINAL ILLNESS RECEIVED FROM MD

_____
Signature /Date

OR (check when appropriate)

_____PATTIENT HAS NO ATTENDING PHYSICIAN AND IS RELYING ON THE HOSPICE TO FULFILL MAJOR ROLE IN DETERMINING AND DELIVERING CARE.