RP-923 (1/95)

PHYSICIAN'S CERTIFICATION FOR APPLICATIONS MADE ON BEHALF OF AGED OR DISABLED PERSONS

_______________________	_______________________	__________
Physician's Name	New York State License No.	Date of Issue

____

Physician's Office Address

____

____

____

Patient's Name

____

Patient's Address

____

Does patient have a physical or mental impairment which substantially limits one or more major life activities(e.g., walking)?

_____ Yes _____ No

Describe: ____

____

____

I certify that all statements made in this section are true and correct to the best of my knowledge and professional belief.

_______________	_______________________
Date	Signature of Patient