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

	hysician's Name	New York State License No.	Date of Issue
	Ph	ysician's Office Address	
		Patient's Name	
		Patient's Address	
patient have a physic	cal or mental impairment w	which substantially limits one or more major	life activities(e.g., walkin
Describe:			
	ents made in this section	are true and correct to the best of my know	ledge and professional be