MARYLAND MEDICAL ASSISTANCE PROGRAM

PHYSICIAN'S STATEMENT OF INCAPACITATION

Date ____________________

This is to certify that _________________________has been under my professional care from __________ to ___________ for treatment of _______________________. I certify that he/she is (check one): _________ capable __________ incapable of participating in the application process including the signing of the application.

____
Signature of Physician

____
Print Name of Physician

____

____
Phone Number

____
Address