

# Physicianâ€™s Incapacity Attestation

**Patient Name:**

**Date of Birth:**

**Medical Diagnosis:**

**Nature and Extent of Incapacity:**

**Date Incapacity Began:**

**Expected Duration of Incapacity:**

**Physicianâ€™s Name:**

**Physicianâ€™s Signature:**

**Date:**

*This form attests that the patient named above is under my care and is incapacitated as described.*