STATE OF CONNECTICUT **PHYSICIANS CERTIFICATE**

OF TOTAL AND PERMANENT DISABILITY

To be used only when accepted proofs of disability from Social Security Administration, Veteran's Administration, or other governmental offices are not obtainable.

I, _____, am familiar with the Social Security
(Physician's name)

Administration's requirements for establishing Total and Permanent Disability status.

In my opinion _____ meets or exceeds all
(applicant's name)

such requirements and is totally and permanently disabled.

To the best of my knowledge this disability began on _____.
(date of disability)

_____ _____
(Physician's signature) (date signed)

_____ _____
(print physician's name) (MD license # - **required**)