Licensed Physician's Statement of Disability

Applicant

Name	
Account #	Phone #
Service Address	Customer Address (if different):
Email Address (if available):	

Physician

Only the following professional classifications are authorized to sign on behalf of Applicant:

Physician & Surgeon – MD or DO, Podiatrist – DPM, Naturopath – ND, Advanced Registered Nurse Practitioner – ARNP, Physician's Assistant – PA.

Print or Type Name of Physician	
Professional Classification	Phone #
Business Name and Address	
Email Address (if available):	

Applicant's Type of <u>Permanent</u> Disability:

- ☐ Cannot walk 200 feet without stopping to rest
- ☐ Severely limited in ability to walk due to arthritic, neurological, or orthopedic condition.
- ☐ Cannot walk without use of assistive device
- ☐ Uses portable oxygen
- ☐ Restricted by lung disease to such an extent that forced expiratory respiratory volume, when measured by spirometry, is less than one liter per second, or the arterial oxygen tension is less than 60 mm/hg on room air at rest
- ☐ Class III or IV impairment by cardiovascular disease under the standard accepted by the American Heart Association
- ☐ Legally blind

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signature_____ Date_____