Physician’s Statement
Bloom Township Disabled Services 2020

Applicant Information

Applicant Name ______________________

Address ______________________

City ____________ Zip ____________

Phone Number ______________________

Patient's Name ______________________

Date Patient became Disabled ______________________

What is the nature of the disability ______________________

Can the patient perform basic lawn maintenance? ____________

Physician Information

Name ______________________

Address ______________________

City ____________ Zip ____________

I am a licensed physician with an established relationship with the patient lasting longer than 6 months. I have examined the patient and determined the client has a physical disability prohibiting them from performing basic lawn care functions that has lasted or will last for longer than 12 months.

Physician's Signature ______________________

Date ____________