Statement Of Certifying Physician

Patient's Name: _____

Address: _____

City: _____ State: ___ Zip: _____

SSN: _____ Phone: _____

HIC #: _____

Secondary Insurance: _____

Date of Birth: _____ Male☐ Female☐

The patient has one or more of the following conditions:

1. The patient has diabetes mellitus.
2. The patient has one or more of the following conditions: (Check all that apply)
   - ☐ History of partial or complete amputation of the foot.
   - ☐ History of previous foot ulceration.
   - ☐ History of pre-ulcerative callus.
   - ☐ Peripheral neuropathy with evidence of callus formation.
   - ☐ Foot deformity.
   - ☐ Poor circulation.

I am treating this patient under a comprehensive plan of care for his/her diabetes. The patient needs:

- ☐ Special shoes and inserts because of his/her diabetes.
- ☐ Ankle Foot Gauntlet

I certify that all of the preceding circled statements are true.

Physician signature: _____

Physician Name: _____

Physician UPIN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date: _____