Form: 380_V01

PHYSICIAN'S CERTIFICATION OF INCAPACITY

Return this Form to: MPI: Retirement Benefits • P.O. Box 1999 • Studio City, CA 91614-0999
Toll-Free: (855) 275-4674 • Fax: (323) 877-2223 • Email: service@mpiphp.org

PARTICIPANT'S INFORMATION

Name (please print)	MPID	Date of Birth	
Address	**City**	**State**	**Zip**
Phone	**Email**		

PHYSICIAN'S INFORMATION

Name (please print)				
Specialty		**Medical License #**		
Address		**City**	**State**	**Zip**
Phone	**Fax**	**Email**		

PHYSICIAN'S FINDINGS

1. Does the patient **lack** the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a decision for him/herself, the ability to reach an informed decision, and the ability to communicate such decisions?

   ☐ Yes ☐ No

2. The nature of the impairment (incapacity) is: ☐ Physical ☐ Mental

   Date incapacity started: _____

3. Diagnosis: _____

   _____

   Is the patient currently diagnosed as terminally ill with a life expectancy of fewer than two years? ☐ Yes ☐ No

   Date of Initial Diagnosis: _____ Date Participant was last examined by you: _____

4. Is the impairment considered total and permanent? ☐ Yes ☐ No

   If "No", what is the anticipated duration of the impairment? _____

PHYSICIAN'S CERTIFICATION

I, the undersigned, a practicing licensed physician or therapist, hereby certify under penalty of perjury, that my answers to the foregoing questions are complete and true to the best of my knowledge, information and belief.

Physician's Signature (Signature stamp is not acceptable) Date

THIS FORM MUST BE COMPLETED AND RETURNED TO MPI.
(Faxes or e-mail must be sent directly from the Physician's office to MPI. Photocopies will NOT be accepted.)