STATEMENT OF CERTIFYING PHYSICIAN

Patient Name: _____ Date of Birth: _____

1) This patient has diabetes mellitus:

□ Type II □ Type I

2) QUALIFYING CONDITIONS: I have diagnosed and am including my notes showing that this patient has one or more of the following:

□ Poor Circulation
□ Foot Deformity
□ Peripheral Neuropathy with evidence of callus formation
□ History of pre-ulcerative callus
□ History of previous foot ulceration
□ History of partial or complete amputation of the foot

3) I am treating this patient under a comprehensive plan for care of his/her diabetes. □ Yes □ No

4) This patient needs special shoes (extra depth or custom molded) because of his/her diabetes. □ Yes □ No

5) I have had an in-person visit with this patient within the past six months, during which diabetes management was addressed.
The date of that visit was _____/_____/_____

KINDLY INCLUDE THIS COMPLETED FORM AND YOUR CLINICAL NOTES ON THE ABOVE NAMED PATIENT AND FAX TO 718-509-3578. THANK YOU. ☺

PHYSICIAN SIGNATURE: _____
(MUST BE AN M.D.OR D.O.)

PHYSICIAN NAME: _____ NPI: _____

PHYSICIAN PHONE: _____ DATE: _____

PHYSICIAN ADDRESS: _____

818 FOREST AVE, STATEN
ISLAND, NY 10310
PHONE: 718-981-9000 / FAX: 718-509-3578