

**SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF APPROPRIATENESS
OF WITHDRAWAL OR WITHHOLDING OF LIFE
SUSTAINING TREATMENT ON BEHALF OF**

**CERTIFICATION
ON CAPACITY**

Declaration # (SDMC Use Only)

(Patient's Name)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

A. STATEMENT OF ATTENDING PHYSICIAN

1. I, _____, am an attending physician for the patient,
(Print Physician's Name)
_____ and my professional License Number is _____.
(Print Patient's Name)

2. My office address and phone number are:

(Street) (City) (State) (Zip)

Phone: () _____ Fax: () _____

3. I find to a reasonable degree of medical certainty that the patient lacks capacity to make health care decisions.

The cause and nature of the patient's mental disability/incapacity (Diagnosis) is:

The extent and probable duration of this mental disability/incapacity is:

4. The information and statements which I have provided are to the best of my knowledge complete and truthful.

Signature of Attending Physician

Date

11. The information and statement which I have provided are to the best of my knowledge complete and truthful.

Signature Consulting Physician/Licensed Psychologist

Date

**TO BE COMPLETED BY THE
ATTENDING PHYSICIAN OR CONSULTANT**

12. A request for a decision to withdraw or withhold life-sustaining treatment requires one of the above attending or consulting physicians or licensed psychologists to meet one of the following criteria

_____ is either (select at least one)
Print Name Physician/Licensed Psychologist

- employed by a developmental disabilities services office MHL § 13.17
- has been employed for a minimum of two years to render care and service in a program operated, licensed or authorized by the Office for Persons with Developmental Disabilities (OPWDD)
- has been approved by the Commissioner of the Office for Persons with Developmental Disabilities (OPWDD).

Signature Physician/Licensed Psychologist

Date