Physician Certification

Date:

Physician Name
Address
City, State, Zip Code

RE: _____ _____
Child's Name Date of Birth

Dear Dr. _____:

A copy of the Individualized Family Service Plan (IFSP) developed for this child is attached. As the child's primary care provider, your input continues to be important.

1. The IFSP team has recommended the following services:

(List services recommended on IFSP)

2. The following recommended services require certification that they are medically necessary:

_____ Physical Therapy
_____ Occupational Therapy
_____ Speech

I certify and approve that the therapy services recommended above are medically necessary for this child. I have reviewed and agree with the attached IFSP.

_____ _____
Physician Signature Date

Thank you,

_____

Name / Title

Return this form to:
Name, address, city / state / zip code, fax number